

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

*John* Do not use this space.

18254  
2299

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
Township Blue Primary Registration District No. \_\_\_\_\_  
City Leeds (No. 15) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Marie Garrett  
(a) Residence No. 2620 Leach St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 1 yrs. 1 mos. 6 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 4 1900  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 29 4 12  
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work clerk (b) General nature of industry, business, or establishment in which employed (or employee) \_\_\_\_\_ (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Billings, Mo (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Albert Garrett  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Arkansas  
12. MAIDEN NAME OF MOTHER Lucy Branch  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT J.B. Wash. (Address) Leeds, Mo

15. FILED 5/18 1929 M.M. Crane REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17 1929  
17. I HEREBY CERTIFY, That I attended deceased from May 4<sup>th</sup>, 1929, to May 17, 1929, that I last saw her alive on May 17, 1929, and that death occurred, on the date stated above, at 12:15 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary Tuberculosis

CONTRIBUTORY (SECONDARY) 31 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? microscopical (Signed) George P. Hill, M.D.

5/18, 1929 (Address) 202 Oggle St., R.D. No. 10.  
\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL Rt. 11 5/19 1929

20. UNDERTAKER W. H. West ADDRESS 416 West 15<sup>th</sup>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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