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

Do not use this space.

34412

1. PLACE OF DEATH

County: MARION — Registration District No.: 547 — File No.: 254

Township: MASON — Primary Registration District No.: 3029 — Registered No.: 2545

City: HANNIBAL (No. LEVERING HOSPITAL St. 6 Ward)

2. FULL NAME SUSIAN BARRETT

(a) Residence. No. 918 BROADWAY St., 2 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
FEMALE	WHITE	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 3 1868

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
61	2	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: RETIRED
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): PITTSFIELD, ILL.

PARENTS

10. NAME OF FATHER: J. W. BARRETT
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ill
12. MAIDEN NAME OF MOTHER: SUSIAN WILSON
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.

14. INFORMANT: Miss Nellie Barrett
(Address) Hannibal Mo.

15. FILED 10-25, 1929 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-19-1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Oct 15, 1929 that I last saw her alive on Oct 15, 1929, and that death occurred, on the date stated above, at 9:50 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brights Disease

131 (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [signature] M. D.

, 19 (Address) Hannibal Mo

*State the DISEASE CAUSING DEATH, or in deaths 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
Mt. Olivet Cemetery	10-22-1929
20. UNDERTAKER: James Donnell	ADDRESS: Hannibal Mo

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.