

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

Do not use this space.

12579

File No. _____
Registered No. **1505**
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Ham Primary Registration District No. 100
City H.P. (No. 2714, Oliver)

2. FULL NAME

Miss Grace Marriott
(a) Residence No. 2714 Oliver St. 11 Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 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) June 22 1910

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 9 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 930
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) no

10. NAME OF FATHER J E Marriott

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no

12. MAIDEN NAME OF MOTHER Bertie Rounton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no

14. INFORMANT Pharney O Marriott
(Address) 2714 Oliver St

15. FILED 4/6 30 M. M. Ginn REGISTRAR
arr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/5/30 1930

17. I HEREBY CERTIFY, That I attended deceased from 4/2 1930, to 4/5 1930 that I last saw her alive on 4/5 1930, and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis chronic
following flu pneumonia
18 mos ago

(duration) 1 yrs. 6 mos. ds. Pulmonary tuberculosis
CONTRIBUTORY (SECONDARY) (duration) 1 yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Eldon - Mo -

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Subrigatory

(Signed) J Henry West M. D.

4/6 19 30 (Address) 920 West 13th St

*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. Ship

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Eldon Mo 4/6/30 1930

20. UNDERTAKER ADDRESS

H. F. Mayberry City

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.

