

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

Do not use this space.

38129

File No. _____

Registered No. 73

1. PLACE OF DEATH

County Rafayette Registration District No. H60
Township Polk Primary Registration District No. H27H
City Higginsville No. _____ St. _____ Ward _____

2. FULL NAME

Mrs. Cora (Morris) Garrison
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Garrison
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 28, 1892
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
39 8 13
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(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)

10. NAME OF FATHER John Morris
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) England
12. MAIDEN NAME OF MOTHER Rebecca Brown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio

14. INFORMANT Mr. Frank Garrison
(Address) Higginsville Mo

15. FILED 11/12 1931 Bessie Porter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 11 1931

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1931, to Nov 11 1931, that I last saw h alive on _____, 19____, and that death occurred, on the date stated above, at 2 P - m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma breast -
50
50 over (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

1 DID AN OPERATION PRECEDE DEATH? Yes, DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Histology of
Johnnie Pharoque has
(Signed) Higginsville, Mo.
11/12 1931 (Address)

*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 Dates City Cemetery DATE OF BURIAL 11/13 1931

20. UNDERTAKER Kiefer & Memershagen ADDRESS Higginsville 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.

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

