

FILED DEC 17 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41099  
State File No. 5195  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>	
c. LENGTH OF STAY (in this place) <b>40 yrs.</b>		d. STREET ADDRESS (If rural, give location) <b>43 W. 58th Terr.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>43 W 58th Terr.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Letitia</b> b. (Middle) <b>W</b> c. (Last) <b>Garrett</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 7, 1949</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 29, 1866</b>		9. AGE (In years last birthday) <b>83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>A. Bowers</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Fullerton</b>		14. NAME OF HUSBAND OR WIFE <b>Samuel C. Garrett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Robert B. Garrett 43 W 58th Terr.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		DUPLICATE			<b>3 days</b>
ANTECEDENT CAUSES		DUE TO (b) <b>Hypertensive cardiovascular disease</b>			<b>20 years</b>
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <b>Generalized arterio sclerosis</b>			<b>20 years</b>
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>443x</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Nov. 10, 1949**, to **Dec 7, 1949**, that I last saw the deceased alive on **Dec 6, 1949**, and that death occurred at **8:30 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Blaine Z. Hibbard</b> (Degree or title) <b>Blaine Z. Hibbard M.D.</b>			23b. ADDRESS <b>411 Alameda Rd. KEMO</b>		23c. DATE SIGNED <b>Dec 7, 1949</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>12-8-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Muncie</b>		24d. LOCATION (City, town, or county) (State) <b>Leavenworth, Kansas</b>

DATE REC'D BY LOCAL REG. <b>12-8-49</b>		REGISTRAR'S SIGNATURE <b>Geraldine Holmes</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Stine &amp; McClure Kansas City, Mo.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Anna ...

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *A J Allen*

Licensed Embalmer No. 1418

P. O. Address *J E M*

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.