

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

Do not use this space.

15025
14

1. PLACE OF DEATH

County Montgomery Registration District No. 595
Township Upper Route Primary Registration District No. 4353
City Willsville, Mo. St. _____ Ward _____

File No. _____
Registered No. 14

2. FULL NAME Maranda Brett

(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. 24 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) widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph Brett
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July - 16 - 1858
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 9 3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 235
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Callaway Co
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Leakeath Welborn
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Christina Foxworth
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Virginia

14. INFORMANT Shirley Joseph Brett
(Address) Willsville, Mo.

15. FILE Mar 30 31 Mrs O.D. Pruitt
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 19 1931
17. I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1931, to April 19, 1931, that I last saw h. _____ alive on April 18, 1931, and that death occurred, on the date stated above, at 7 12 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of the intestine;
46C.7
_____ (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

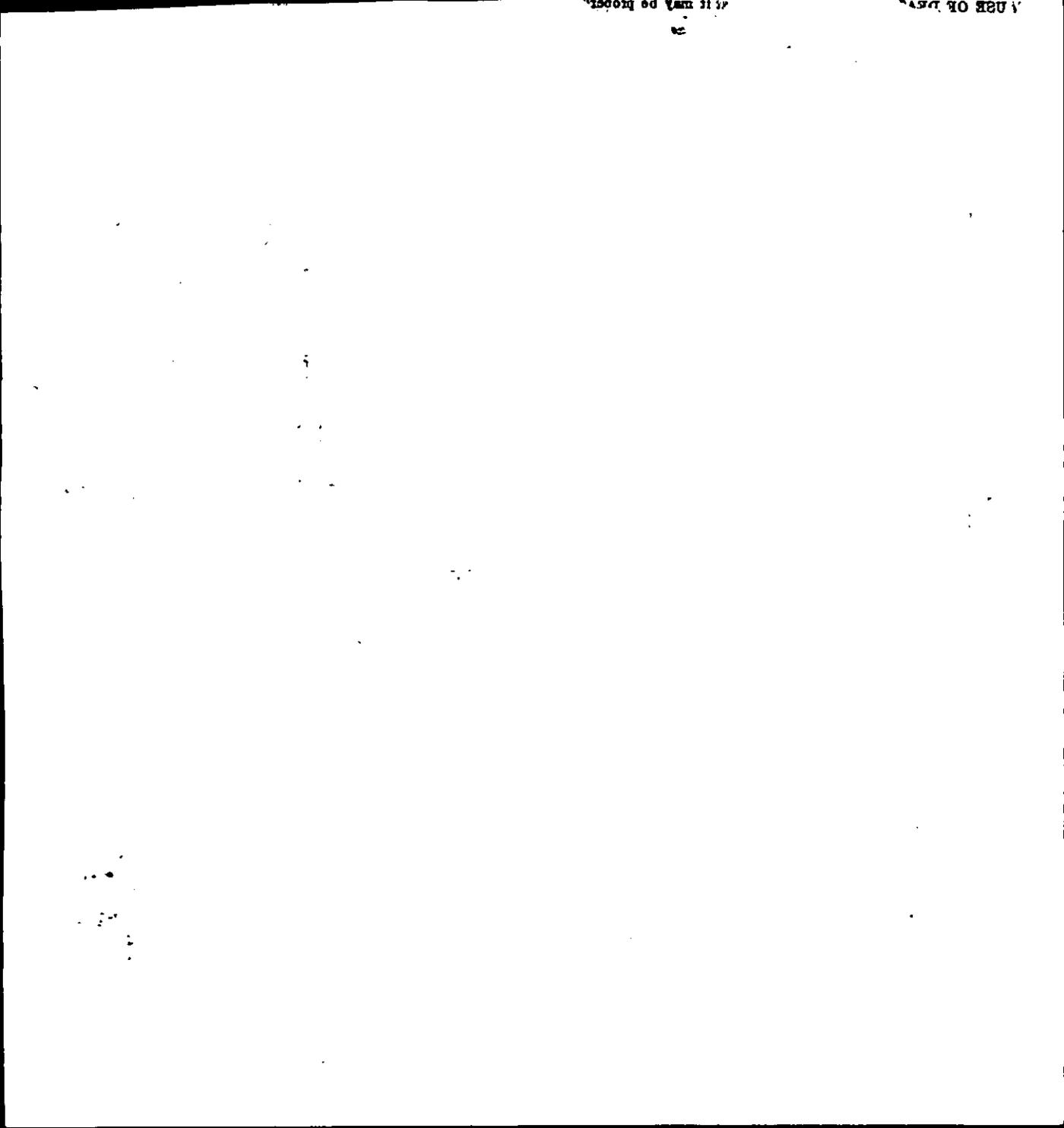
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Feb. 24 31
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS Examining of Specimens
(Signed) Paul Manifer, M. D.
Feb. 20 31 (Address) Montgomery Co., Mo.

*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 Cypress Cemetery DATE OF BURIAL April 20 1931

20. UNDERTAKER J.W. Kubler ADDRESS Willsville Mo

MAY 27 1931



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Montgomery Registration District No. 595- File No.
Township Primary Registration District No. 4353 Registered No. 14
City Wellsville (No.) St. Ward

2. FULL NAME

Maranda Brett
(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 ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(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

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED April 25, 1931 M. O. Prewitt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 19 1931

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Carcinoma of the intestine involving the ascending colon and sigmoid flexure
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 46e
(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), M. D.
, 19 (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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of

SUPPLEMENTARY

S-15025