

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

29688  
Do not use this space.

REC'D SEP 19 1939

**1. PLACE OF DEATH**

(a) County Maxion Registration District No. 547  
 (b) Township Mason Primary Registration District No. 2079  
 or City Hannibal (c) Street No. 912 Mark Twain Ave Registered No. 249  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

**2. PRINT FULL NAME**

600 ANNAT Garry  
 (a) Residence, No. 912 Mark Twain Ave St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOW  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF Patrick  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April-14-1858  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
81 4 8  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug-21-1939

22. I HEREBY CERTIFY, That I attended deceased from June 15, 1939, to Aug 21, 1939  
 I last saw her alive on Aug 20, 1939. Death is said to have occurred on the date stated above, at 11:45 a.m.  
 The principal cause of death and related causes of importance were as follows:

Arterio sclerosis Date of onset  
97  
 Other contributory causes of importance:  
Arterio sclerotic Dementia

Name of operation None Date of  
 What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury....., 19.....  
 Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury  
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify  
 (Signed) H. B. Daniel, M. D.  
 (Address) 227A, Broadway

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana  
 FATHER 13. NAME John Greeley  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland  
 MOTHER 15. MAIDEN NAME Catherine Corbett  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland  
 17. INFORMANT (ADDRESS) William Garry  
912 Mark Twain Hannibal MO  
 18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mary's DATE Aug-24-1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) James O'Donnell  
Hannibal, Mo  
 20. FILED Aug 28 1939 W. Crisher  
 Local Registrar.

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.

---

---

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. *3889*

P. O. Address *Samuel P. Mc*

**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, above space should be left blank.**