AUG 6 1927

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

Do not use this space.

20892

1. PLACE OF DEATH
County Carroll — Registration District No. 135
Township — Primary Registration District No. 3010
City Carrollton — (No. ..... St. ..... Ward)
File No. .....
Registered No. 56

2. FULL NAME Marie Brevitt Rea

(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 5 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: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Hal Rea
6. DATE OF BIRTH (MONTH, DAY AND YEAR): 7-4-1900
7. AGE — YEARS: 27 — MONTHS: X — DAYS: 13 — IF LESS than 1 day, ..... hrs. or ..... min.
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): .....
(c) Name of employer .....
9. BIRTHPLACE (CITY OR TOWN): West Point
(STATE OR COUNTRY): Iowa

PARENTS
10. NAME OF FATHER: Geo. B. Brevitt
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Henderson Co. Ill.
12. MAIDEN NAME OF MOTHER: Kate Shafer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Henderson Co. Ill.

14. INFORMANT: Mrs. Geo. Brevitt
(Address): Carrollton Mo
15. FILED 7-18-1927 Mrs E E Farnham REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-17 1927
17. I HEREBY CERTIFY, That I attended deceased from 6-8-27, 19..., to 7-17, 19 27 that I last saw h. alive on 7-17, 19 27 and that death occurred, on the date stated above, at 9.15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Pulmonary Tuberculosis
Tuberculosis of Stomach & Bladder
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Tubercular Laryngitis
(duration) yrs. mos. 30 ds.

18. WHERE WAS DISEASE CONTRACTED? —
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms —
(Signed) H. B. Downers, M. D
, 19 (Address) Carrollton 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: Oak Hill Cem
DATE OF BURIAL: 7-19 1927
20. UNDERTAKER: Woodley Fun. Home
ADDRESS: Carrollton 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.