

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

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

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.

PLACE OF DEATH Andrew
County Andrew
Township Patrick's Registration-District No. 13 File No. 37
or Patrick's Primary Registration District No. 5018 Registered No. 73
Village _____
or _____
City _____ (NO. _____ St. _____ Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Eliza Jane Barber

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE W.P.V. SINGLE Yes
MARRIED _____
WIDOWED _____
OR DIVORCED _____
(Write the word)

DATE OF BIRTH April 22, 1837
(Month) (Day) (Year)

AGE 76 yrs. 7 mos. 25 ds.
If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Shelby Co Ky.

NAME OF FATHER Allen Sloan

BIRTHPLACE OF FATHER (City or town, State or foreign country) Indiana

MAIDEN NAME OF MOTHER Blackmore

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Indiana

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter C. Myers
(ADDRESS) Savannah Mo

Filed July 1, 1916 E. C. Jefferies REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 16, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1912, to Dec 16, 1915,
that I last saw her alive on Aug 1, 1915,
and that death occurred, on the date stated above, at 3:45 m.

The CAUSE OF DEATH* was as follows:
Organic Heart,
Pulmonary Infarction
92A
95B (Duration) 3 yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.
(Signed) Walter C. Myers M. D.
Savannah 1915 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Union Star DATE OF BURIAL Dec 17, 1915

UNDERTAKER H. S. & I. E. Cole ADDRESS Sting City

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

PLACE OF DEATH

County *Andrew*
Township *Empire*
or
Village
or
City

Registration District No. *13*

File No.

Primary Registration District No. *5018*

Registered No.

23

(NO.)

St. _____ Ward _____

[If death occurred in a hospital or institution give its NAME instead of street and number]

FULL NAME

Eliza Jane Barber

PERSONAL AND STATISTICAL PARTICULARS

SEX _____
COLOR OR RACE _____
Female White
SINGLE _____
MARRIED _____
WIDOWED _____
OR DIVORCED _____
(If use the word)

DATE OF BIRTH

(Month) _____ (Day) *1* (Year) _____

AGE

~~86~~ mos. _____ ds. _____
IF LESS than
1 day, _____ hrs. _____
or _____ min.?

OCCUPATION

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

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

_____ 191_____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Dec 16
(Month) _____, 191*5*
(Year)

I HEREBY CERTIFY, that I attended deceased from

_____ 191_____, to _____ 191_____,

that I last saw h_____ alive on _____, 191_____,

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

(Address)

M. D.

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence.

PLACE OF BURIAL OR REMOVAL

Union Star

DATE OF BURIAL

Dec 17, 191*5*

UNDERTAKER

W. J. E. Cole

ADDRESS

St. Mary City

MARGIN RESERVED FOR BINDING

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

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