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.

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

PLACE OF DEATH

County Texas

Township Jackson

or

Village ~~Oscar Mo~~

or

City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. 866 File No. 3904

Primary Registration District No. 6145 Registered No. 1

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

FULL NAME Elizabeth Ann Barker

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF BIRTH 4 (Month) 4 (Day), 1820 (Year)

AGE 92 yrs. 9 mos. 3 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work house Wife 10

(b) General nature of industry, business, or establishment in which employed (or employer) 11

BIRTHPLACE (City or town, State or foreign country) State of Tennessee

PARENTS

NAME OF FATHER Wiley Pierce

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

MAIDEN NAME OF MOTHER Elizabeth Hancock

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Byron DeForest

(ADDRESS) Oscar Mo

Filed 1/14/ 1913 R. C. Haggard REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan (Month) 7 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 1, 1913, to Jan 4, 1913, that I last saw her alive on Jan 4, 1913, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Bronchitis

Contracted 1864

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Asthma

(Duration) 48 yrs. 9 mos. ___ ds.

(Signed) O. C. McBride M. D.

Jan 8, 1913 (Address) Oscar Mo

*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 0 yrs. 9 mos. ___ ds. In the State 60 yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? Ashley Texas Co Mo

Former or usual residence Ashley " " "

PLACE OF BURIAL OR REMOVAL Boon Creek Cemetery

DATE OF BURIAL Jan 8 1913

UNDERTAKER None

ADDRESS —

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ _____ St.; _____ Ward)

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

FULL NAME _____

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.

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

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____
(Month) (Day) (Year)

AGE _____ yrs. _____ 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)

PARENTS

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
_____, 191_____
(Month) (Day) (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 _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

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

Contributory _____
(Secondary)

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

(Signed) _____ M. D.

_____, 191_____ (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	DATE OF BURIAL
	_____, 191_____
UNDERTAKER	ADDRESS