

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 Cities or Woods
County _____
Township _____
or
Village _____
or
City Sedalia mo (NO. _____) St.; _____ Ward _____

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

Registration District No. 668 File No. 37051
Primary Registration District No. 3032 Registered No. 268

FULL NAME Robert W. Barnett

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

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widowed
(If write the word)

DATE OF BIRTH May 31 1886
(Month) (Day) (Year)

AGE 77 yrs. 6 mos. 12 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) 10-11 131 1/2

BIRTHPLACE (City or town, State or foreign country) Kentucky

PARENTS
NAME OF FATHER Barnett
BIRTHPLACE OF FATHER Hartford - Ohio
(City or town, State or foreign country) Kentucky
MAIDEN NAME OF MOTHER not known
BIRTHPLACE OF MOTHER not known
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Barnett
(ADDRESS) Sedalia mo

Filed Nov 15 1913 A. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 13 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 9, 1913, to Nov 13, 1913, that I last saw him alive on Nov 13, 1913, and that death occurred, on the date stated above, at 90 m. The CAUSE OF DEATH* was as follows:

Practical disease
probably (Duration) 2 yrs. — mos. — ds.
Contributory (SECONDARY) X
(Duration) _____ yrs. — mos. — ds.

(Signed) Ed. Wood M. D.
Nov 14 1913 (Address) Sedalia 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 _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Crown Hill Cemetery DATE OF BURIAL Nov 15 1913
UNDERTAKER McLaughlin Bros ADDRESS Sedalia mo

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____ Ward _____

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE
		MARRIED
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	WIDOWED
		OR DIVORCED
AGE	(Month) _____ (Day) _____ (Year) _____	(Write the word)

DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	IF LESS than
		1 day, _____ hrs. or _____ min. ?
AGE	(Month) _____ (Day) _____ (Year) _____	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

OCCUPATION	(City or town, State or foreign country)	IF LESS than
		1 day, _____ hrs. or _____ min. ?
BIRTHPLACE	(City or town, State or foreign country)	_____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

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REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(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 _____

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 REGENT 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

DATE OF BURIAL

UNDERTAKER

ADDRESS

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.

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