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 Worth

Township Middlefork or Village ~~Worthy~~ Mo. or City ____ (NO. ____ St.; ____ Ward)

Registration District No. 1112 — File No. 3740

Primary Registration District No. 6213 — Registered No. ____

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

FULL NAME Elsie Asher

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

DATE OF BIRTH Oct (Month) 8 (Day), 1844 (Year)

AGE — 69 yrs. 2 mos. 26 ds. If LESS than 1 day, ____ hrs. or ____ min.? —

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

BIRTHPLACE (City or town, State or foreign country) Buchanan Co

PARENTS

NAME OF FATHER Benjamin Barnes

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

MAIDEN NAME OF MOTHER Rebecca Garrison

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. P. Asher

(ADDRESS) Worthy Mo

Filed Jan 4. 1914. W. F. Barnes REGISTRAR

I. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan (Month) 3 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 10, 1913, to Jan 2, 1914, that I last saw h alive on Jan 2, 1914, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Gall Stones

126

131 (Duration) ____ yrs. 6 mos. ____ ds.

Contributory (SECONDARY) Acute Nephritis (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Dr J. K. Phipps M. D.

Jan 3 1914 (Address) Gilt City 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 State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL Barnes Cemetery — DATE OF BURIAL Jan 4 1913

UNDERTAKER Lester Pettijohn — ADDRESS Worth, Mo

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

PLACE OF DEATH

County_____

Township _____ or Village_____ or City _____

Registration District No._____ Primary Registration District No._____

File No._____ Registered No._____

(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 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

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.