

PLACE OF DEATH

County Pike

Township _____

or Village _____

City Ashley

Registration District No. 683

Primary Registration District No. 4467

File No. _____

Registered No. _____

2058

FULL NAME

Elizabeth A. Barrow

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>Jan.</u> <u>21</u> <u>1840</u> (Month) (Day) (Year)		
AGE <u>75</u> yrs. <u>13</u> mos. <u>13</u> ds.		If LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>House Wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>at Home</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Bowling Green Mo</u>		
PARENTS	NAME OF FATHER <u>Joseph Obannon</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Virginia</u>	
	MAIDEN NAME OF MOTHER <u>Julia Strother</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Virginia</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Barrow

(ADDRESS) Ashley mo

Filed Jan 8, 1915 J. E. Rees

REGISTRAR

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

1 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 30 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from August 25th, 1914, to Jan 4th, 1915, that I last saw her alive on Nov 17th, 1914, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:
Endocarditis
92B

6 months (Duration) yrs. mos. ds.

Contributory Don't know
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) J. E. Walter M. D.
Jan 4th, 1915 (Address) Bowling Green 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 Ashley Cemetery DATE OF BURIAL Jan 6, 1915

UNDERTAKER Walter E. Moore ADDRESS Bowling Green Mo

PLACE OF DEATH

County _____

Township _____
or _____

Village _____
or _____

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

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

St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE _____ MARRIED _____ WIDOWED _____ OR DIVORCED _____ (If fit the word)

DATE OF BIRTH _____

AGE _____ (Month) _____ (Day) _____ (Year) _____

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____, _____

REGISTERAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____ (Day) _____, 191____ (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) _____, 191____ (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

DATE OF BURIAL

UNDERTAKER

ADDRESS