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. THIS IS A PERMANENT RECORD

**PLACE OF DEATH**

County Pettis

Township Dresden

or

Village

or

City (NO. St.; Ward)

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

Registration District No. 672 File No. 22568

Primary Registration District No. 5895 Registered No. 3

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

**FULL NAME** Garnett D. Barrow

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | White | Single |

DATE OF BIRTH: May (Month) 9 (Day) 1901 (Year)

AGE: 14 yrs. 2 mos. 12 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Grangen Iowa

PARENTS

NAME OF FATHER: Dreby D. Barrow

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill.

MAIDEN NAME OF MOTHER: Anna M. Bentley

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Anna M. Barrow

(ADDRESS) Dresden Mo.

Filed 7-28-, 1915. A B Ferguson REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 21 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from ___, 191___, to ___, 191___, that I last saw h___ alive on July 21, 1915, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Suffocation in
mitral Elevation
accelerator

182 (Duration) ___ yrs. 16 mos. ___ ds.

Contributory (SECONDARY)

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

(Signed) J F Elder M. D.

7-28, 1915 (Address) La Mint 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: Dresden Mo. DATE OF BURIAL: July 22 1915

UNDERTAKER: B. F. Purcell & Morle ADDRESS

PLACE OF DEATH

County_____

Township _____
*or*
Village_____
*or*
City _____ (NO._____, _____ St.:_____ Ward)

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

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]

**FULL NAME**_____

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH

_____ (Month) _____ (Day) 1_____ (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<br>_____, 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.