V. S. No. 2.

MARGIN RESERVED FOR BINDING

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 Buchanan

Township agency

or

Village

or

City (NO. St.; Ward)

Registration District No. 80 File No. 20469-6

Primary Registration District No. 4048 Registered No. 20

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

FULL NAME John E Barnett

PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word) |
|---|---|---|
| Ale | White | Married |

DATE OF BIRTH Feb (Month) 2 (Day), 1892 (Year)

AGE 24 yrs. 4 mos. 22 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(1) Trade, profession, or particular kind of work Farmer 210 N 75 E
(2) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) agency Mo.

NAME OF FATHER John Barnett

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

MAIDEN NAME OF MOTHER Sarah Cobb

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grover C Barnett

(ADDRESS) Fazier MO.

Filed 6/24/16, 191__ R F Dwell REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June (Month) 24 (Day), 1916 (Year)

I HEREBY CERTIFY, that I ~~attended deceased~~ serve from on June 24-1916, 191__, that I last saw h__ alive on ___, 191__, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Accidental Automobile Turning over on him Broken Neck

(Duration) Sudden yrs. mos. 175 ds.

Contributory (SECONDARY) Alcholism

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

(Signed) John Wesser M. D.

6 24, 1916 (Address) Deputy Coroner 1697 St Joseph 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 | DATE OF BURIAL |
|---|---|
| agency | June 25, 1916 |
| UNDERTAKER | ADDRESS |
| H A Sullivan | agency |

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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# MISSOURI STATE BOARD OF HEAL

## 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 hospital or institu give its NAME in of street and numbe

**FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

DATE OF BIRTH

..... (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) (Ye

I HEREBY CERTIFY, that I attended deceased f

....., 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. .....

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) ..... M.

....., 191... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, st (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

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