LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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**

50735

Registration District No. 821 File No. 190
Primary Registration District No. 6070 Registered No.

1 PLACE OF DEATH
County Scott
Township Richland
or
Village Sikeston
or
City (NO. St. Ward)

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

2 FULL NAME Mary Lucile Barger

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Female
4 COLOR OR RACE white
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Infant

6 DATE OF BIRTH Nov. 29 (Month) 1918 (Day) (Year)

7 AGE yrs. mos. 2 ds.
If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Sikeston Mo

PARENTS
10 NAME OF FATHER Ewell H. Barger
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Crittenden Co. Ky
12 MAIDEN NAME OF MOTHER Tat" Gresham
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sikeston Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. G. Gresham
(Address) Sikeston Mo

15 Filed 12/14, 1918 W. E. Ferris Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Dec. (Month) 1 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 30 —, 1918, to Dec. 1, 1918, that I last saw h~~im~~ alive on Dec. 1 —, 1918, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Intrapuncular Closing of heart Valve —

1 hr (Duration) 50 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. A. Mayfield M. D.
Dec 2, 1918 (Address) Sikeston Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL Sikeston Mo
DATE OF BURIAL 12/2, 1918

20 UNDERTAKER H. J. Welsh
ADDRESS Sikeston Mo

# LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

**1 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 in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** .....

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.

WRITE PLAINLY WITH INK

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ..... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ..... 191..... ..... Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 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.

18 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 .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191..... |
|---|---|
| 20 UNDERTAKER | ADDRESS |