LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

16971-B

PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every statement should be supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County McDonald

Township Pineville

or

Village

or

City (NO. St.: Ward)

Registration District No. 1149 File No. ~~19884~~-4

Primary Registration District No. 1696 Registered No.

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

2 FULL NAME William Starnes

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feby 15 1873 (Month) (Day) (Year)

7 AGE: 47 yrs. 1 mos. 20 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country): McDonald Co Mo

PARENTS

10 NAME OF FATHER: McHenry Starnes

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

12 MAIDEN NAME OF MOTHER: Sarah Sawyers

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

I THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

14. (Informant): Sarah Jane Starnes

15. (Address): Pineville Mo

Filed Apr 7 1920 A J Fohr Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: Apr 5 (Month) (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 27, 1920, to Apr 5, 1920, that I last saw him alive on Apr 5, 1920, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows: Pneumonia - Lob

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A J Fohr M. D.

191 (Address) Pineville 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: Sulphur Springs Ark

DATE OF BURIAL: Apr 7 1920

20 UNDERTAKER: F L Carnes

ADDRESS: Pineville

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

**MISSOURI STATE BOARD OF HEA**
**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 .....

## 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 ..... 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. ..... 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 ..... |
|---|---|
| 20 UNDERTAKER | ADDRESS |