

PLACE OF DEATH

County Shelby
 Township Sack River
 or
 Village
 or
 City Shelby (NO. _____ St.: _____ Ward)

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

Registration District No. 830 File No. 21192³⁶
 Primary Registration District No. 6091 Registered No. _____

FULL NAME Maria Barton

(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>Negro</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widow</u> (If write the word)
DATE OF BIRTH <u>about</u> <u>South Knoxville</u> (Month) (Day) (Year) <u>1845</u>		
AGE <u>72</u> yrs. _____ mos. _____ 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) _____		

BIRTHPLACE
(City or town, State or foreign country) Marion Co Ky.

PARENTS	NAME OF FATHER <u>unknown</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>unknown</u>
	MAIDEN NAME OF MOTHER <u>unknown</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W R DAWK
 (ADDRESS) Shelby Mo

Filled May 26, 1920. Mittie Clay
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 26, 1920
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 10, 1920, to May 24, 1920, that I last saw her alive on May 24, 1920, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH was as follows:

diabetes

59
 (Duration) 3 yrs. _____ mos. _____ ds.

Contributory Exp. pneumonia
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Van Hook M. D.
May 25, 1920 (Address) Shelby 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 Shelby Mo DATE OF BURIAL May 27, 1920

UNDERTAKER Egza Peter ADDRESS Shelby Mo

PLACE OF DEATH

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

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.

County _____

Township _____
or _____

Village _____
or _____

City _____ (NO. _____)

Registration District No. _____

Primary Registration District No. _____

File 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 MARRIED WIDOWED OR DIVORCED (If file 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 business, or establishment in which employed (or employer)
(b) General nature of industry.

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____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him 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. 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 _____, 191____

UNDERTAKER

ADDRESS