LOCAL REGISTRAR'S RECORD DO NOT TEAR LEAF OUT

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

D

1 PLACE OF DEATH
County Dallas
Township Grant
or
Village Louisburg Mo
or
City ..... St. ..... Ward)

Registration District No. 242 File No. 28964-a
Primary Registration District No. 5335 Registered No. 70

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

2 FULL NAME Bertha Barkenbrough

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F
4 COLOR OR RACE W
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married
6 DATE OF BIRTH Oct (Month) 18 (Day) 1920 (Year)
7 AGE 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?
8 OCCUPATION
(a) Trade, profession, or particular kind of work Houses Keeper
(b) General nature of industry business, or establishment in which employed (or employer) Home work
9 BIRTHPLACE (City or town, State or foreign country) England

PARENTS
10 NAME OF FATHER Geo Edwards
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) England
12 MAIDEN NAME OF MOTHER Susan Humphrey
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry D Carbrough
(Address) Buckland Kans

15 Filed Oct 18, 1920 W E Gowman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 18 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 10, 1920, to Oct 18, 1920
that I last saw her alive on Oct 18, 1920
and that death occurred, on the date stated above, at 4:30 a.m.
The CAUSE OF DEATH* was as follows:
Acute Colitis
120 B
105
(Duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W E Gowman M. D.
Oct 18, 1920 (Address) Louisburg 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 Buckland Kans
DATE OF BURIAL 10/18/1920
20 UNDERTAKER C E Routh
ADDRESS Buffalo Mo

LOCAL RE[illegible]ORD—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.

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**