AY 2 1927

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

Do not use this space.

File No. 11463

Registered No. 259

Registration District No. 318

Primary Registration District No. 5439

1. PLACE OF DEATH
County: Greene
Township: N. Springfield
City: Springfield (No. R.F.D. #6 St. Ward)

2. FULL NAME: Eugene Leroy Barrett

(a) Residence. No. R.F.D. #6 St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m
4. COLOR OR RACE: w
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): child

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF: child

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 29 1926

7. AGE: Years 5 | Months 5 | Days 21 | If LESS than 1 day, ...hrs. or ....min.

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

9. BIRTHPLACE (CITY OR TOWN): Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER: E. J. Barrett
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Ky.
12. MAIDEN NAME OF MOTHER: Willie Davis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Ky.

14. INFORMANT: E. J. Barrett
(Address): R.F.D. #6

15. FILED 4/22 1927 O. C. Horst M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 4-20 1927

17. I HEREBY CERTIFY, That I attended deceased from April 15, 1927, to 4-20 1927, that I last saw h— alive on 4-20 1927, and that death occurred, on the date stated above, at 11:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart failure
Myocarditis
Chronic
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Diphtheria
(duration) yrs. 10 mos. 11 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Cosner M.D.
4/27 1927 (Address) Springfield Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: East Lawn CEMETERY
DATE OF BURIAL: 4/23 1927

20. UNDERTAKER: W. Morse
ADDRESS: Mo.

Report statement of OCCUPATION is very important. Insert full name of husband or father, if married, widow or divorced. Insert full name of husband or father, if married, widow or divorced.

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CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH
County: Greene Registration District No.: 318 File No.:
Township: N. Campbell Primary Registration District No.: 5439 Registered No.: 259
City: (No. St. Ward)

2. FULL NAME: Eugene Leroy Barnett

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 29, 1922

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
4	5	21	

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

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED: 4/22, 1927. O. C. Forest M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr 20 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw h..... alive on ....., 19...., 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.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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

SUPPLEMENTAL

S-11463