

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

Do not use this space.

26532

1. PLACE OF DEATH

County..... **Buchanan**

Registration District No. **85**

Township.....

Primary Registration District No. **1001**

City..... **St. Joseph,**

(No. **523 Hamburg Ave.**)

File No.

Registered No. **932**

St. Ward)

2. FULL NAME

Nannie Owens Barbee

(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 **22** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Beal M. Barbee

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct. 10, 1867**

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
59	11	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... **At Home.**

(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) **Saline Co., Mo.**

10. NAME OF FATHER

Robert M. Owens

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Saline Co., Mo.**

12. MAIDEN NAME OF MOTHER **Sarah C. Wiles**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Tenn.**

14. INFORMANT **Mt. Beal M. Barbee**

(Address) **523 Hamburg Ave.**

15. FILED **10** 19**27**
John G. W. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept. 11, 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Sept. 8**, 19**27**, to **Sept. 11**, 19**27** that I last saw her alive on **Sept. 15**, 19**27**, and that death occurred, on the date stated above, at **10.40 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial nephritis

CONTRIBUTORY **High blood pressure** (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF BIRTH.....

19. DID AN OPERATION PRECEDE DEATH? **NO DATE OF**

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Thomas Raymond, M. D.**

9/13, 1927 (Address) **St. Joseph, 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

Mt. Mora Cemetery

DATE OF BURIAL

Sept. 13, 1927

20. UNDERTAKER

Walter Meischoffer 1302 Faraon St.

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.

ST 24 1927

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