

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

1960

1. PLACE OF DEATH

County Jackson
Township Oak Grove
City Oak Grove (No.)

Registration District No. 402
Primary Registration District No. 4237

File No.
Registered No. 5
St. Ward)

2. FULL NAME

Mary Francis Barnes

(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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Elebridge Barnes 10-1857

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 10-1857

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 9 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Grant City
(STATE OR COUNTRY) mo.

10. NAME OF FATHER J. P. Seitz

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Morris

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT J. R. Barnes
(Address) Independence, mo.

15. Filed Jan 31, 1929 A. Mann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 17 1929

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 Oak Grove mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

oral gas
asphyxiation
(duration) yrs. mos. ds. 178c

CONTRIBUTORY (SECONDARY) ✓
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) E. E. Perry, M. D.
1/20, 1929 (Address) Oak Grove, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Grove, Mo. DATE OF BURIAL 1-21 1929

20. UNDERTAKER L. O. Webb Oak Grove, Mo.
ADDRESS

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.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.)..... St..... Ward.....

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min.

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)

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)

PARENTS

14. INFORMANT
 (Address)

15. FILED....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from
 that I last saw h....., 19....., to
 alive on....., 19....., and that
 death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY
 (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPTSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed).....

, 19 (Address)

M. D

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

DEATH information should be carefully supplied in plain terms, so that it may be properly understood. PHYSICIANS should be consulted if the cause of death is doubtful. OCCUPATION is very important.

N. B.—Full Name of Information
 Person OF DEATH in plain terms,

S-1960