

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

Do not use this space.

4999

**1. PLACE OF DEATH**

County Scott Registration District No. 831 File No. 19  
 Township Rockland Primary Registration District No. 6070 Registered No. \_\_\_\_\_  
 City Sikeston (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Barrie Roper  
 (a) Residence. No. 203 Mathews 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>
5A. <del>IN-MARRIED</del> WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>Sam Roper</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 29-1896</u>		
7. AGE <u>42</u>	YEARS <u>11</u>	MONTHS <u>12</u>
		IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Home</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) <u>Wynonville</u> (STATE OR COUNTRY) <u>Gen</u>		
10. NAME OF FATHER <u>W. C. Gray</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Wynonville</u> (STATE OR COUNTRY) <u>Gen</u>		
12. MAIDEN NAME OF MOTHER <u>Corrie Gray</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Wynonville</u> (STATE OR COUNTRY) <u>Gen</u>		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 to Jan 11, 1929, to Jan 11, 1929 that I last saw h. \_\_\_\_\_ alive on Jan 10, 1929, and that death occurred, on the date stated above, at 6:30 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Pulmonary Tuberculosis  
9 2, 11 (duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF BIRTH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH. no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? NO

WHICH TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
 (Signed) Ham Kendig M. D.  
 (Address) Sikeston 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 Sikeston Cemetery DATE OF BURIAL Jan 13 1929

20. UNDERTAKER John Allitt ADDRESS Sikeston 770

14. INFORMANT Wyatt Roper  
(Address) Sikeston Mo

15. FILED 2/10/29 Walter E. Duda REGISTRAR

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.

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Kendig