1929

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

Do not use this space.

12476

File No. .....

Registered No. 2998

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1093

City ..... (No. Mulkanphy Hospital St. ..... Ward)

2. FULL NAME Iow Barrett

(a) Residence. No. 3833 Page 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June Unknown 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	61	9	Unknown	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work NONE
(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) Iowa

PARENTS

10. NAME OF FATHER Hy W. Fox

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

12. MAIDEN NAME OF MOTHER Margaret Brabham

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

14. INFORMANT Mrs A. C. Troop
(Address) 3833 Page

15. FILED ....., 1929 Mary C. Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 7th 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h..... alive on ..... and that death occurred, on the date stated above, at 9 30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries - Fractured Skull

..... (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) due to falling down stairs

Unresponsive ..... (duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....

3/8, 1929 (Signed) John Finney, M. D.
(Address) 1 S. Fourth Corner

*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
Laurel Hill	Mar 9 1929
20. UNDERTAKER	**ADDRESS**
M. H. Marshall	604 Union

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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