

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

Do not use this space.

1929

File No. 13657
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH
County Wayne Registration District No. 880
Township _____ Primary Registration District No. 45-39
City Greenville (No. _____) St. _____ Ward _____

2. FULL NAME Abner Barrow
(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 32 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29, 1858

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<u>70</u>	<u>9</u>	<u>2</u>		

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

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Jackson Co., Ill.

10. NAME OF FATHER Marion F. Barrow

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Jackson Co., Ill.

12. MAIDEN NAME OF MOTHER Elizabeth Thomason

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Randolph Co., Ill.

14. INFORMANT Ellsworth Barrow (Address) Greenville, Mo

15. FILED _____, 19 _____ REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-31-1929

17. I HEREBY CERTIFY, That I attended deceased from 3-31-1929 to 3-31-1929 that I last saw him alive on 3-31-1929, and that death occurred, on the date stated above, at 4:35 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
97 1/2 (duration) 3 1/2 hours

CONTRIBUTORY Arterio-sclerosis (SECONDARY) (duration) _____ yrs. mos. 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.

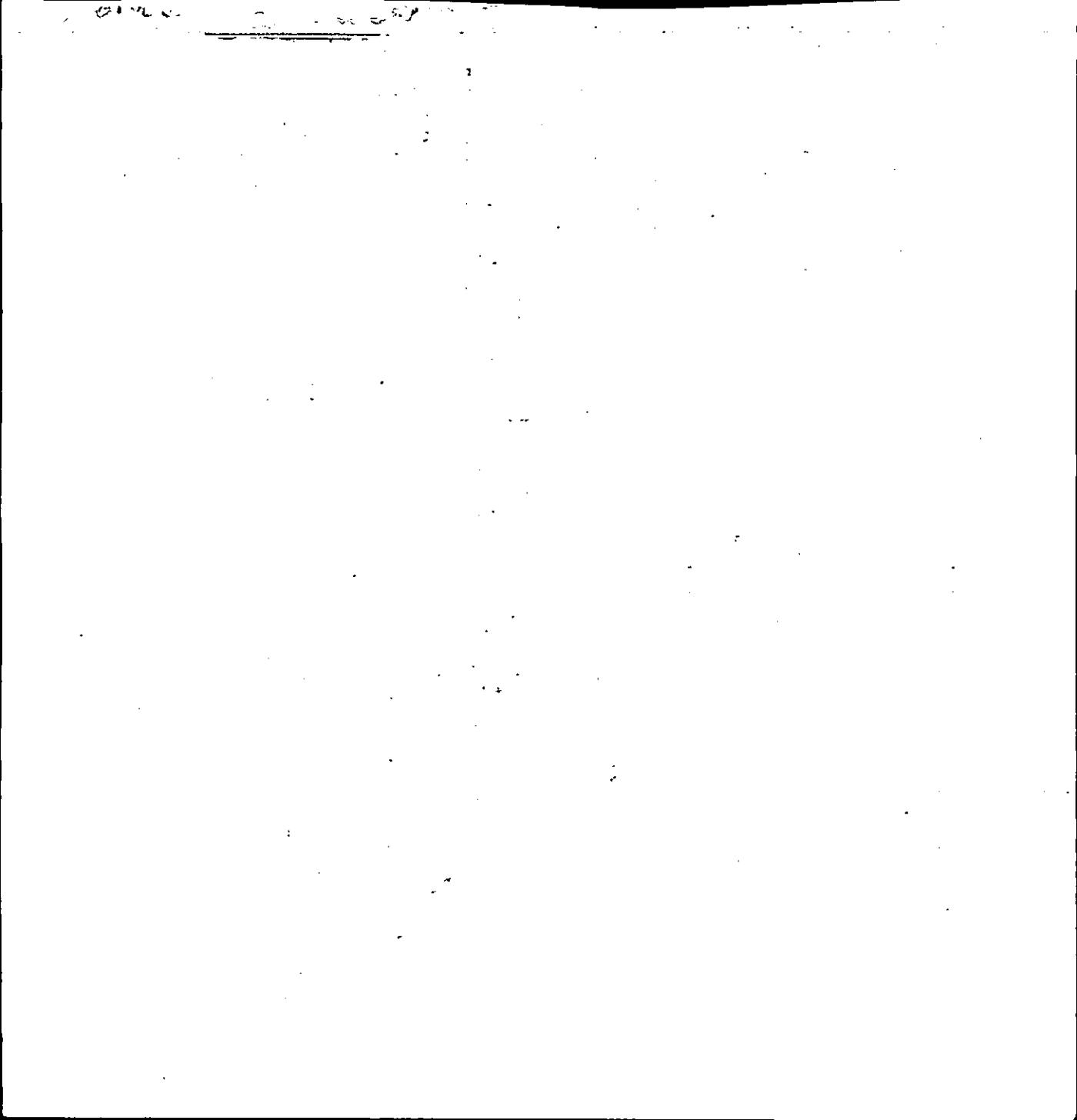
WHAT TEST CONFIRMED DIAGNOSIS? _____ (Signed) Geo F. Wagner M. D. 4-2, 1929 (Address) Greenville, Mo

*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 Nickman Cemetery DATE OF BURIAL 4-3-1929

20. UNDERTAKER G.C. Yates ADDRESS Piedmont Mo

PARENTS X



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Wayne Registration District No. 890 File No.
Township Primary Registration District No. 43-39 Registered No.
City Greenville (No.) St. Ward)

2. FULL NAME

Obner Barwood

(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 m (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)

14. INFORMANT..... (Address)

15. FILED 7/1 1929 A. G. Tangle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/31 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 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY A

SUPPLEMENTARY

S-13657