

AUG-22 1929

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

Do not use this space.

23725

1. PLACE OF DEATH

County Andrain
Towship Centre
City Farber (N)

Registration District No. 912
Primary Registration District No. 6232A

File No. _____
Registered No. 31
St. _____ Ward) _____

2. FULL NAME

Margaret Isabel Barnes

(a) Residence. No. _____ St. _____ Ward. _____

(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS**3. SEX**

Female White

4. COLOR OR RACE

widow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF**

Joshua Barnes

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

March 29-1848

7. AGE

YEARS MONTHS DAYS
81 3 20
If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmers wife
(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 July 20 19 29

Mollie Fugua
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 17 19 29

17.

I HEREBY CERTIFY That I attended deceased from July 17, 19 29, to July 17, 19 29, that I last saw him alive on July 17, 19 29, and that death occurred, on the date stated above, at 9:17 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis
XIA
762 (duration) yrs. 1 mos. 13 da.
CONTRIBUTORY senility
(SECONDARY) (duration) 3 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTEDIF NOT AT PLACE OF DEATH: at place of death**19. DID AN OPERATION PRECEDE DEATH?** no DATE OF 8WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? Physical(Signed) M. M. M. M. D., 19 (Address) Farber, 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

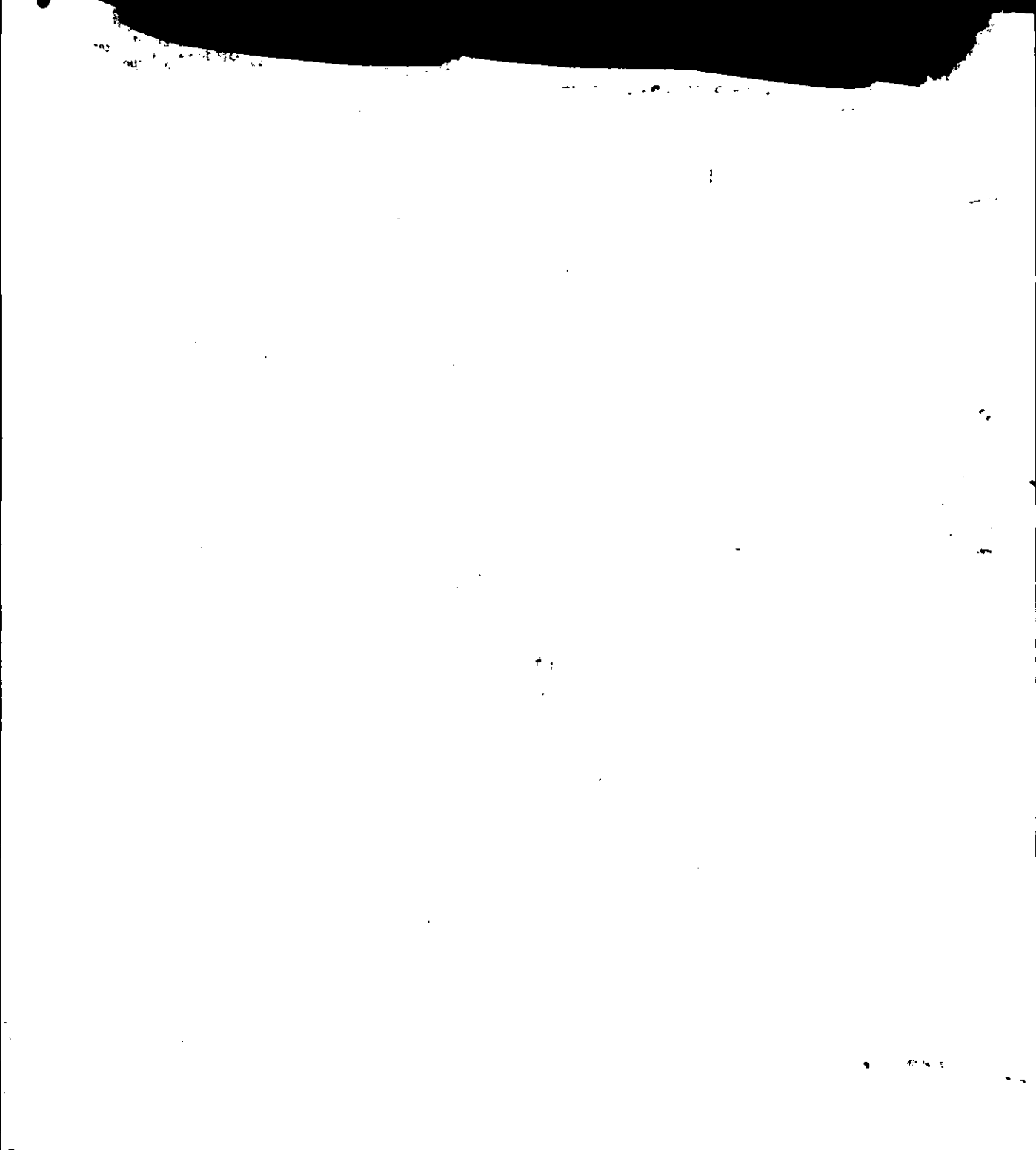
DATE OF BURIAL

Farber, Mo. July 21 19 29

20. UNDERTAKER

ADDRESS

H. C. Granger Radonia Mo.



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

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-2010 BY 60322 UCBAW

1. PLACE OF DEATH

County Greene

Registration District No. 912

File No. 6292a

Township Greene

Primary Registration District No. 6292a

Registered No. 6292a

City Greene (No. 1)

St. Mo. Ward 1

2. FULL NAME

Margaret Isabel Barnes

(a) Residence. No. 1 St. 1 Ward. 1

(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

F

4. COLOR OR RACE

W

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

Wid

**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)

PARENTS

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 119, 19.29

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

July 19 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:

Paralysis
of the brain
due to
arteriosclerosis
(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)

Emphysema
(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 VIOLENCE, state
(1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDE, or
HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE 119, 19.29

20. UNDERTAKER

ADDRESS

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, and that it is properly classified. Exact statement of OCCUPATION is very important.

REGISTRATION FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-23725