

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

Do not use this space.

5341

**1. PLACE OF DEATH**

County Jasper Registration District No. 408 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3020 Registered No. \_\_\_\_\_  
 City Carthage Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Margaret Elene Harbin  
 (a) Residence. No. 727 E. 6th St. \_\_\_\_\_ Ward \_\_\_\_\_ (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Sept 25<sup>th</sup> 1929

**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
0      4      6

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work Child.  
 (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)** Carthage Missouri

**10. NAME OF FATHER** Nugh Webb  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Missouri  
**12. MAIDEN NAME OF MOTHER** Aleen Harbin  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** Mo.

**14. INFORMANT (Address)** Guy Harbin

**15. FILED** Feb 30 1930 (07) Stephens REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**15. DATE OF DEATH (MONTH, DAY AND YEAR)** Feb 1<sup>st</sup> 1930

**17. I HEREBY CERTIFY, That I attended deceased from** Jan 22, 1930, to Feb 1, 1930, that I last saw him alive on Jan 21, 1930, and that death occurred, on the date stated above, at 8:50 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Bronchial Pneumonia  
107A (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**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) J. E. Baker, M. D.

209, 1930 (Address) Carthage 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** Cedar Hill Cemetery **DATE OF BURIAL** 2/3 1930

**20. UNDERTAKER** Wm. Drake **ADDRESS** Carthage

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Gasper Registration District No. 408 File No. ....  
 Township ..... Primary Registration District No. 2020 Registered No. ....  
 City Carthage (No. ....) St. .... Ward)

**2. FULL NAME**

Margaret Gene Harbin

(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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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 4/13 19 30 E. J. Keschau REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 1 - 19 30

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:  
Bronchial Pneumonia  
with measles as  
precipitating cough or other  
cause (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1000 (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

6 19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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