

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

Do not use this space.

**20142**

**1. PLACE OF DEATH**

County Franklin Registration District No. 605  
Township Como Primary Registration District No. 5804  
City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Virginia Barnes  
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-22-1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>1</u>	<u>9</u>	<u>3</u>	

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) Parma  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER W.C. Barnes

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

12. MAIDEN NAME OF MOTHER Bernice Rice

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.  
(STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT W.C. Barnes  
(Address) Parma Mo.

15. FILED 6/28/30 Mrs. C.S. Staekman  
By Mrs. V.B. Stevenson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) \_\_\_\_\_ 19\_\_\_\_

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 25, 1930  
that I last saw h. alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Dysentery  
136 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) No (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

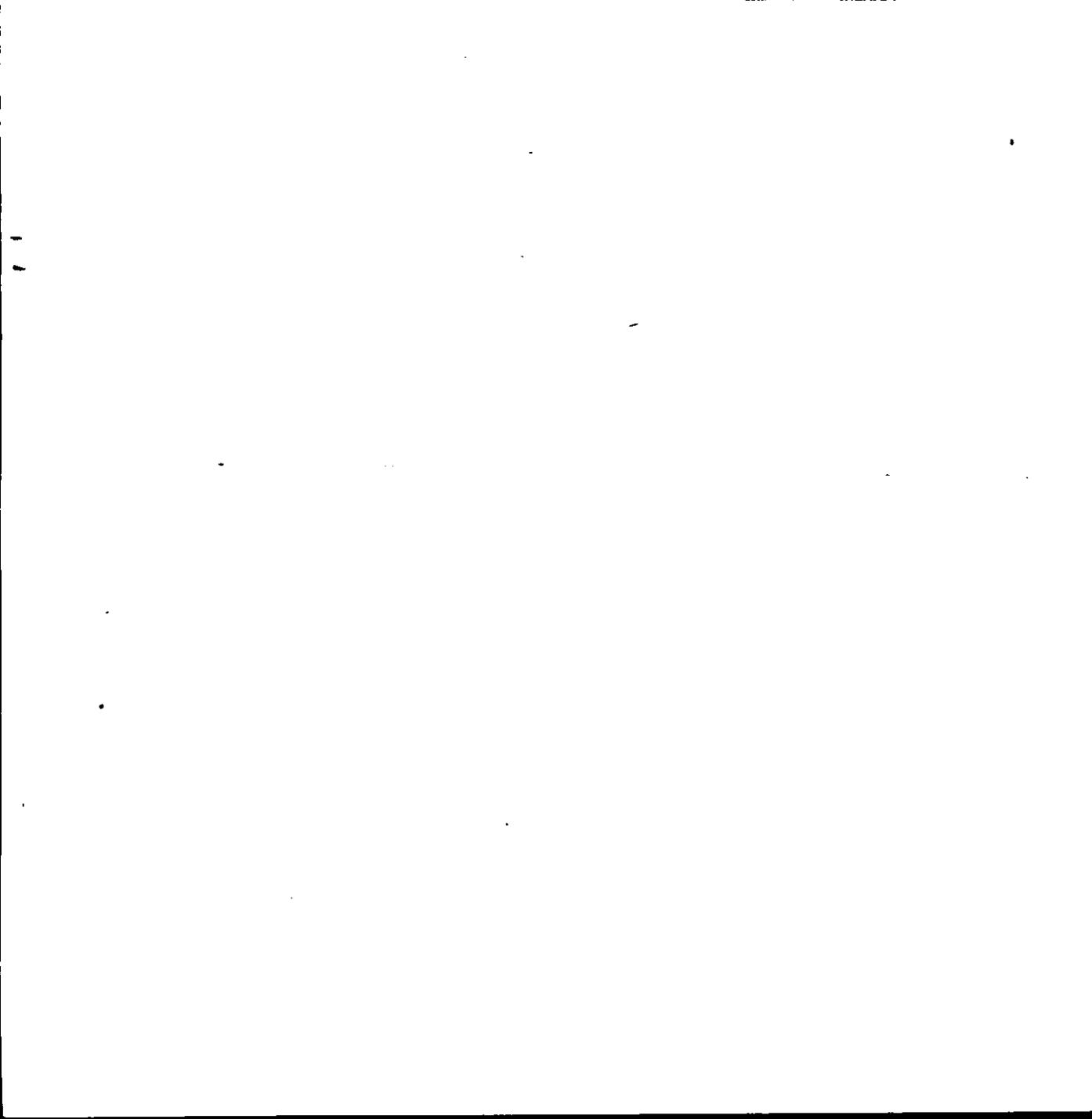
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) Geo. H. ..., M. D.  
, 19\_\_\_\_ (Address) Parma

\*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 Parma DATE OF BURIAL 6/26/30

20. UNDERTAKER L. M. Hill ADDRESS Lebanon Mo.



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

6-30  
ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County New Madrid Registration District No. 605 File No. ....  
Township Cono Primary Registration District No. 3804 Registered No. ....  
City ..... (No. .... St. .... Ward)

**2. FULL NAME** Virginia Barnes

(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(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)

FILED 6/28, 1930 Mrs C. S. Blackman REGISTRAR  
By Mrs V. B. Stevenson

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25th 1930

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 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:

..... (duration) ..... yrs. .... mos. .... ds.  
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  
19

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

S-20142