

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

Do not use this space.

**24065**

**1. PLACE OF DEATH**

County St. Francis

Registration District No. 773

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

Township cc 4

Primary Registration District No. 6018A

Registered No. 108

New Farmington (No. State Hosp. No. 4)

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME Liliana Barreras**

(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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4 1930

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

17. I HEREBY CERTIFY, That I attended deceased from March 20 1930, to July 4 1930, that I last saw her alive on July 3 1930, and that death occurred, on the date stated above, at 4:00 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

arteriosclerosis  
186A  
194B  
97 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

CONTRIBUTORY (SECONDARY) similarity and fracture of rt. hip (2 mos. ago) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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 \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Havana, Cuba (STATE OR COUNTRY) \_\_\_\_\_

IF NOT AT PLACE OF DEATH \_\_\_\_\_

10. NAME OF FATHER Don't Know

8 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

WAS THERE AN AUTOPSY? \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Don't know

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

(Signed) Ralph Hanks M. D.

14. INFORMANT Hosp. Records (Address) State Hosp. No 4

7/4 1930 (Address) Farmington Mo

\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15. FILED 7-4-1930 Farmington Mo T. J. Robinson REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Hill Cemetery DATE OF BURIAL July 7 1930

20. UNDERTAKER Louis H. Bopp ADDRESS Wirkwood

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION of deceased.

30  
31

Mo



**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 St. Francis  
Township.....  
City..... (No..... St..... Ward)

Registration District No. 773  
Primary Registration District No. 6.018 a

File No.....  
Registered No. 108

**2. FULL NAME**

Sienna Bavieras

(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 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)

15. FILED 9-9-30 T.B. Robinson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4 1930

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Artificial Asphyxia

CONTRIBUTORY (SECONDARY) Senility & fracture of hip from fall on floor

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. 1855

\*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

**SUPPLEMENTARY**

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Every item of information should be carefully supplied. Every item of information should be carefully supplied.

S-24065