

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

Do not use this space.

25585

1930 PLACE OF DEATH

County Shannon
Township Low
City Naomi (No. Barnes)

Registration District No. 873
Primary Registration District No. 6075

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

2. FULL NAME Naomi 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 F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 19, 1907

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
22 7 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Winona
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER William Barnes

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

12. MAIDEN NAME OF MOTHER Lura Copeland

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

14. INFORMANT Florida Barnes
(Address) Winona Mo

15. FILED 7-3, 1930 Mabel Beale
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) July 2 1930

17. I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to July 2, 1930 that I last saw him alive on May 1, 1930 and that death occurred, on the date stated above, at 3:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23A

(duration) 1 yrs. 6 mos. _____ ds.

CONTRIBUTORY (SECONDARY) 31

(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 R. L. Davis M. D.
(Signed) _____

7-V, 1930 (Address) Burch Tree 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

Mt Zion

7/3 1930

20. UNDERTAKER

ADDRESS

Wm Rucker

Winona Mo

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

100