

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

Do not use this space.

38225

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

1. PLACE OF DEATH

County Saline
Township Argue River
City Nelson (No. _____)

Registration District No. 798
Primary Registration District No. 603513

2. FULL NAME

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IS MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Emma Barnfield

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-11-1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 | 8 | 10

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Spain
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Robert Barnfield

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

12. MAIDEN NAME OF MOTHER Deeds

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

14. INFORMANT Wm. G. Barnfield
(Address) Nelson Mo.

15. FILED 11/30 1930 Mrs. Hall Williams
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 21 1930

17. I HEREBY CERTIFY, That I attended deceased from November 11, 1930, to November 21, 1930, that I last saw h. was, alive on November 21, 1930, and that death occurred, on the date stated above, at 8:15 P. M.

THE CAUSE OF DEATH¹⁰ WAS AS FOLLOWS:

Influenza followed by pneumonia

11/21/30
CONTRIBUTORY age, run down condition for
(SECONDARY)
last year typhoid (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

20. WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms

(Signed) J. Miller Toicade, M. D.
, 19 (Address) Blackwater, Mo.

¹⁰State 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 Salt Fork Cem DATE OF BURIAL Nov 22, 1930

20. UNDERTAKER L. M. Nelson ADDRESS Nelson 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.

3 1930

