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

13527

1. PLACE OF DEATH
County Pike
Township Cuivre
City Bowling Green (No. ..... St. ..... Ward)
Registration District No. 684
Primary Registration District No. 4408
File No. .....
Registered No. 20

2. FULL NAME C. S. Barney

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

MY 8 6 1932

PERSONAL AND STATISTICAL PARTICULARS

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

5a. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF Dont know

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
About	50			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Highway construction Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 113
(c) Name of employer Mr Kelser

9. BIRTHPLACE (CITY OR TOWN) Dont know
(STATE OR COUNTRY)

PARENTS

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 Mr Kelsey
(Address) Bowling Green

15. FILED 5/10, 1932 Mrs F. Summerkamp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/25 1932

17. I HEREBY CERTIFY, That I attended deceased from 4/25/32 to 4/25/32, 19..., that I last saw h... alive on 4/25/32, 19..., and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Angina Pectoris

CONTRIBUTORY (SECONDARY) ..... (duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED (1)
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Hatlee M. D.
, 19 (Address) Bowling Green, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Belvedere Ill — DATE OF BURIAL April 28, 1932

20. UNDERTAKER W. B. Elmore — ADDRESS Bowling Green

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ... St. ..... Ward)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*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)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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:

.....

.....

.....

.....(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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19

20. UNDERTAKER	ADDRESS

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.

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