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

Do not use this space.

28944

1. PLACE OF DEATH 14
County Calloway
Township ~~Dugwant~~
~~City~~ Ampersand (No. ..... St. ..... Ward)

Registration District No. 105-
Primary Registration District No. 5155-

File No. .....
Registered No. 35

2. FULL NAME Barbara Jean O'Neal

(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)
female	white	baby

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-14-1932

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	9	13	

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

9. BIRTHPLACE (CITY OR TOWN) Fulton
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Clarence O'Neal
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Calloway Co Mo.
12. MAIDEN NAME OF MOTHER Mabel Estes
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Calloway Co Mo.

14. INFORMANT Clarence O'Neal
(Address) Reform, Mo.

15. FILED 9-28, 1933 W H W [illegible] REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-27 1933

17. I HEREBY CERTIFY, That I attended deceased from 9-26, 1933, to 9-27, 1933 that I last saw her alive on 9-27, 1933, and that death occurred, on the date stated above, at 3 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Convulsions with Whooping Cough + Pneumonia.
..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) 9 109A
..... (duration) ..... yrs. ..... mos. ..... ds. 86

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) W O Payne, M. D.
, 19 (Address) R#9 Fulton

*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
Holiness Cemetery	Sept 28 1933
20. UNDERTAKER	ADDRESS
Leo G Wallace	Fulton 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.

OCT 20 1933