

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

Do not use this space.

MAR 24 1934

6183

1. PLACE OF DEATH

County Ray Registration District No. 750
Township 1 N. 1 E. 1 S. Primary Registration District No. 598.5
City Danville (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Eva Barnes
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1986
7. AGE YEARS 48 MONTHS Not obtainable DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

13. NAME John D. Barnes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) W. A. Roberts

18. BURIAL, CREMATION, OR REMOVAL PLACE Plunk DATE Feb 19 1934

19. UNDERTAKER (ADDRESS) _____

20. FILED Feb. 18 1934 C B Johnston Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 17 1934

22. I HEREBY CERTIFY, That I attended deceased from 11/1, 1934, to 2/17, 1934.
I last saw him alive on 1/25, 1934. Death is said to have occurred on the date stated above, at 5:30 m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Aborted insufficiency 11/4/34

Other contributory causes of importance

Name of operation _____ Date of _____

What test confirmed diagnosis? Cerebral Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Clifford G. Smith, M. D.

(Address) Danville, 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.

1. *Chlorophyll a* (Chl *a*) is the primary photosynthetic pigment in most plants and algae. It is a green pigment that absorbs light energy in the blue and red regions of the visible spectrum.