

APR 2 1935 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

7748

1. PLACE OF DEATH

County Shannon
Township Winona
City _____ (No. _____) St. _____ Ward _____

Registration District No. 843
Primary Registration District No. 6074

File No. _____
Registered No. _____

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 J 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 16 1859

7. AGE YEARS 75 MONTHS 6 DAYS 11 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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

FATHER MOTHER

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

13. NAME James Barnes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

15. MAIDEN NAME Mary Ciles

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rosford Wm

17. INFORMANT (ADDRESS) Don Bradley

18. BURIAL, CREMATION, OR REMOVAL

PLACE falling sprs cemetery DATE Feb 28 1935

19. UNDERTAKER (ADDRESS) Wm

20. FILED 4-28-35 Wm Recd

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 27 1935

22. I HEREBY CERTIFY, That I attended deceased from Jan 1932, to Feb 27 1935

I last saw her alive on Feb 25 1935 Death is said to have occurred on the date stated above, at 11:28 a.m.

The principal cause of death and related causes of importance were as follows:

Influenza

Date of onset 1-20-35

Other contributory causes of importance:

Feb 27 1935

1930

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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 _____

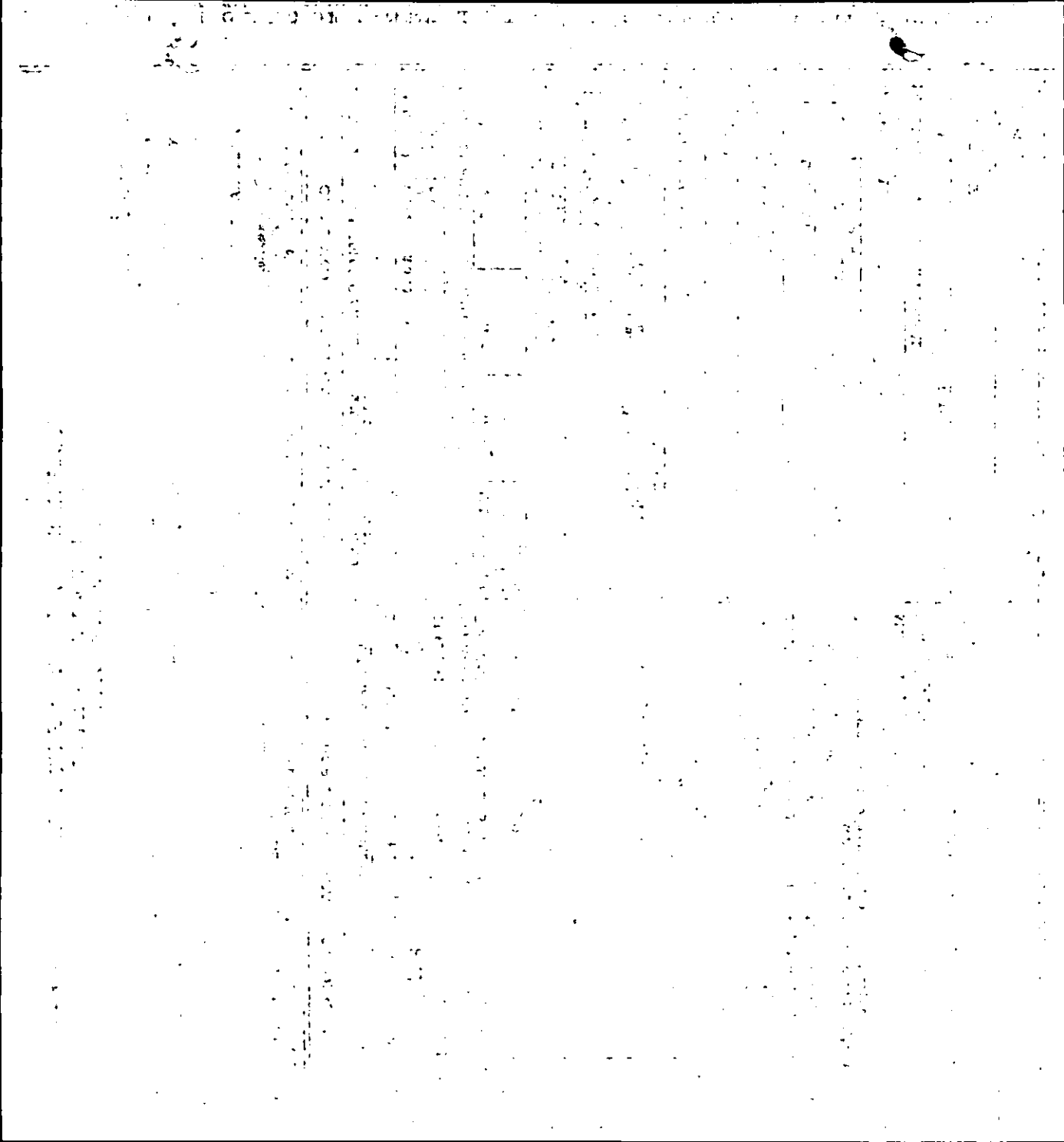
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) W. B. Eudy, M. D.

(Address) Cambridge, Mo



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Shannon

Registration District No. 823

Township

Primary Registration District No. 6074

City

(No.)

File No.

Registered 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 I 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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.
75 6 11

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 5-6 1935 Michael Breen Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 27, 1935

22. I HEREBY CERTIFY, That I attended deceased from

19... to 19...

I last saw him on 19... Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Subacute pneumonia

no malignancy

Name of operation Date of

What test confirmed diagnosis? 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?

If so, specify

(Signed) W. T. Egan M. D.

(Address) 170 W. Breen

MAY 11 1963

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