

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.

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

1. PLACE OF DEATH

County CarterTownship JohnsonCity HunterRegistration District No. 145Primary Registration District No. 5208File No. 18520Registered No. 12

St. _____ Ward _____

2. FULL NAME

Sarah Reddy BarnettHunter

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

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 OFJohn Barnett

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

July 6, 1885

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.515 mo.12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or

particular kind of work

Housewife

(b) General nature of industry,

business, or establishment in

which employed (or employer)

home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Elginore

(STATE OR COUNTRY)

Missouri

PARENTS

10. NAME OF FATHER

Joseph Lee Raper

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

?

(STATE OR COUNTRY)

Carter County, Mo.12. MAIDEN NAME OF MOTHER Cynthia Ann Boyer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

?

(STATE OR COUNTRY)

Carter County, Mo.

14.

INFORMANT Chester Seese

(Address)

Hunter, Missouri

15.

FILED 4/26, 1936Alexander Johnston

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 25 1936

17.

I HEREBY CERTIFY, That I attended deceased from
Dec. 4 18 5 to Jan. 21 1936
 that I last saw him alive on Jan. 24 1936 and that
 death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

BronchopneumoniaSpontaneous(duration) yrs. mos. da. 6 da.

CONTRIBUTORY

Hemolytic Jaundice

(SECONDARY)

with splenomegaly(duration) yrs. mos. da. 9 mos.

18. WHERE WAS DISEASE CONTRACTED

Home

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

clinical(Signed) Dr. John H. Nichols

19

(Address)

Hunter, 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

Hunter, Missouri

DATE OF BURIAL

Jan. 26 1936

20. UNDERTAKER

Bill Whittier

ADDRESS

Hunter, Mo.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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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)
 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..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (circle 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. 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 employee).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

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.....
 that I last saw h..... alive on..... 19....., at.....
 death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED..... (duration)..... yrs. mos. da.

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