

MAY 20 1936

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

Do not use this space.

14829

## 1. PLACE OF DEATH

County Green Registration District No. 318  
Township \_\_\_\_\_ Primary Registration District No. 2001  
City Springfield Mo (No. St. Johns Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 360

## 2. FULL NAME

Lella Barber  
(a) Residence, No. 1055 W. Harrison St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
about 38 Sout know

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. U.P.A.  
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) Unknown13. NAME Hesterly14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown15. MAIDEN NAME Hesterly16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown17. INFORMANT (ADDRESS) Charlie Barber  
Springfield Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Nottawhite Mo DATE April 20 193619. UNDERTAKER (ADDRESS) F.P. Fringe  
Springfield Mo20. FILED 4-19-1936 Ralph W Langston  
Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 18 193622. I HEREBY CERTIFY, That I attended deceased from 4-16-1936 to 4-18-1936

I last saw h. 4-17-1936 alive on 4-17-1936 Death is said to have occurred on the date stated above, at 7 a.m.

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

Bronchial Pneumonia

Date of onset

Other contributory causes of importance:

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. Kelly, M. D.(Address) Springfield 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.

