

OCT 21 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County LacledeRegistration District No. 449Township LebanonPrimary Registration District No. 4267City Lebanon (No. _____)

St. _____ Ward _____

File No. 34593

Registered No. _____

2. FULL NAME

(a) Residence, No. _____
(Usual place of abode)

St. _____ Ward _____

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF ☒6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 6 1937

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

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) Lebanon Mo13. NAME Fay Barnhart14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co Mo15. MAIDEN NAME Bertha Wilson16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co Mo17. INFORMANT (ADDRESS) Fay Barnhart
Phillipsburg Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE New Hope DATE 9/719. UNDERTAKER (ADDRESS) W. E. Helman
Lebanon Mo20. FILED 9-9-37 J. A. McComb Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/6 193722. I HEREBY CERTIFY, That I attended deceased from Sept 4, 1937, to Sept 6, 1937

I last saw h. alive 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:

Stillborn, due to premature separation of placenta

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.

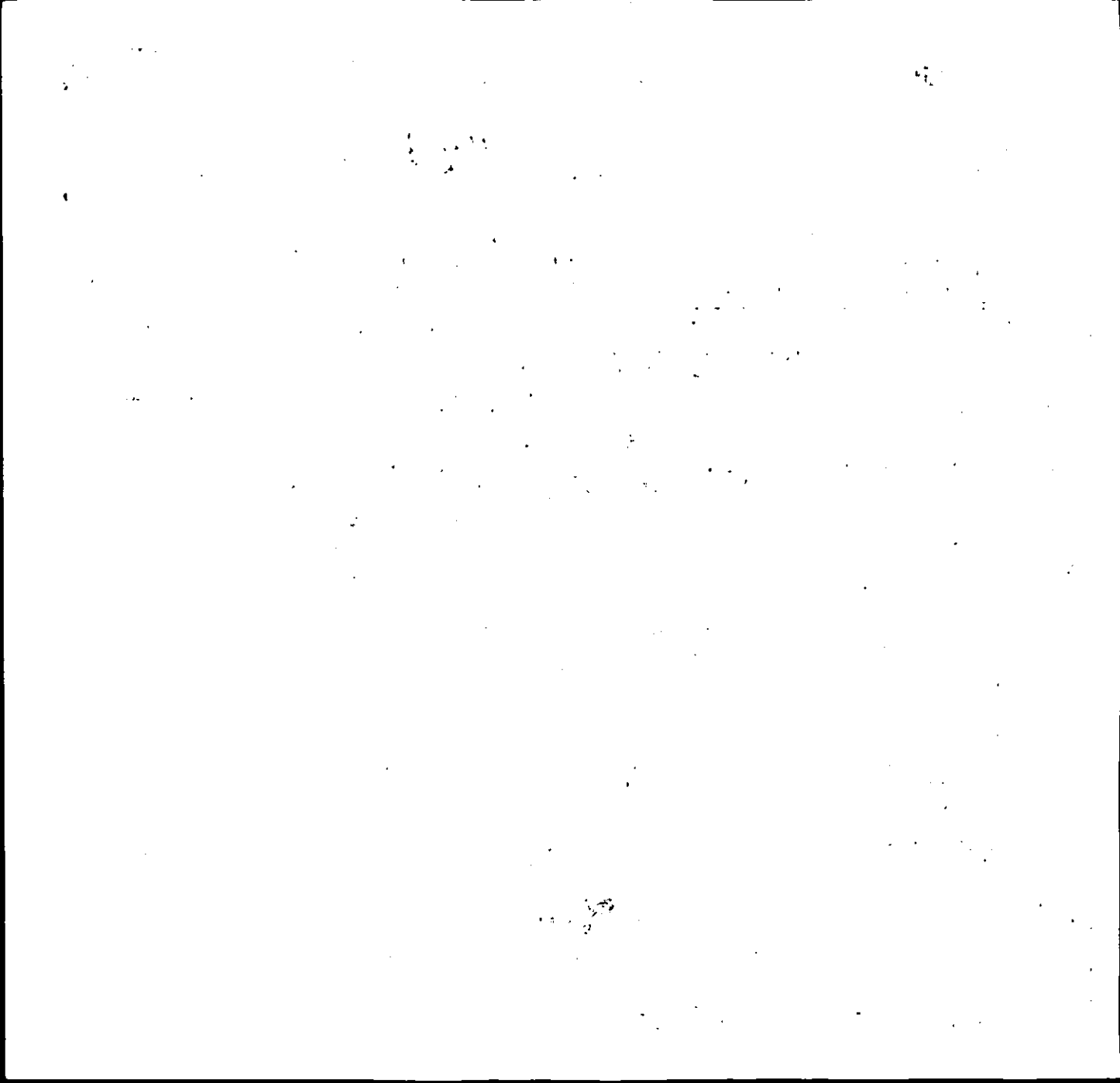
Manner of injury _____

Nature of injury _____

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

If so, specify _____

(Signed) J. A. McComb, M. D.(Address) Lebanon Mo



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

345-93

Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 449
(b) Township Lebanon Primary Registration District No. 4367
(c) City Lebanon (d) Street No. Wallace Hospital Registered No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
Stillborn son of Mrs. Edna Fay Barnhart
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 6-1937

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

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Manner of injury _____

Nature of injury _____

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If so, specify _____

(Signed) J. H. Summers, M. D.

(Address) Lebanon Mo

