

DEC 28 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

42608

1. PLACE OF DEATH

County ShannonRegistration District No. 873Township WinonaPrimary Registration District No. 6074City Shannon(No.)St. Mo Ward

2. FULL NAME

Florence Barnes(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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

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

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

June 2 1913

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ... hrs. or min.

2459

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

Housemaid

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)

Shannon Mo

13. NAME

Wm Barnes

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

Reynolds Co Mo

15. MAIDEN NAME

Lena Copeland

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

Reynolds Co Mo

17. INFORMANT (ADDRESS)

Florida Robbins
Shannon Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Wetzelburg DATE Nov 12 1937

19. UNDERTAKER (ADDRESS)

Gray (W. C.)
Van Buren Mo

20. FILED

12-8 1937 Mahek Boehm
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 11 193722. I HEREBY CERTIFY That I attended deceased from Sept 1 1937 to Nov 11 1937I last saw him alive on Oct 1 1937. Death is saidto have occurred on the date stated above, at 5 P. m.

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

Respiratory Failure

Date of onset

Other contributory causes of importance:

Pulmonary Tuberculosis

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) R. D. Davis, M. D.(Address) Burch Tree 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

42608

Do not use this space.

1. PLACE OF DEATH

(a) County Shannon

Registration District No. 823

(b) Township Shannon

Primary Registration District No. 6074

Registered No. _____

(c) City _____

(d) Street 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

Florence Barnes

(a) Residence, No. _____ St. ☐

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)

S

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.

24

5

9

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.

Housewife

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. FUNERAL DIRECTOR
(ADDRESS)

20. FILED 1-25, 1938 Mabel Beebe
Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 11, 1937

22. I HEREBY CERTIFY, That I attended deceased from

_____ to _____, 19____

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:

Respiratory failure

Date of onset

Other contributory causes of importance:

Pulmonary Tuberculosis

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) R. J. Davis, M. D.

(Address) Bush Tree

