

REC'D OCT 18 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

31594
Do not use this space.

1. PLACE OF DEATH

(a) County Andrew Registration District No. 912
 (b) Township Cairo Primary Registration District No. 6232A Registered No. 29
 (c) City _____ (d) Street No. _____
 (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

WILLIAM E BARNES
 (a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 OF Lemma Jane Barnes

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 25 1871

7. AGE YEARS 67 MONTHS 5 DAYS 14 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farm
 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) Pittsfield Ills.

FATHER 13. NAME Joshua Barnes
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER 15. MAIDEN NAME Maggie Cunningham
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT (ADDRESS) Mr. W. E. Barnes

18. BURIAL, CREMATION, OR REMOVAL PLACE Farber Mrs DATE Sept 9 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. S. Water Vandalia

20. FILED Sept. 15, 1938 Carrie F. Utterback Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 7, 1938

22. I HEREBY CERTIFY, That I attended deceased from May 6, 1938, to Sept 7, 1938

I last saw him alive on Sept 7, 1938. Death is said to have occurred on the date stated above, at 10:00 AM. The principal cause of death and related causes of importance were as follows:

Acute Myocarditis
Preexisting Stenosis

Date of onset
May 6, 38
May 25, 38

Other contributory causes of importance:
Acute Glomerular Nephritis

May 28, 38

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? No
 If so, specify _____

(Signed) Dr. R. L. Marshall
27 (Address) Vandalia Missouri

MINNAPOLIS BOARD OF HEALTH
 DIVISION OF PUBLIC HEALTH
 DIVISION OF PUBLIC HEALTH

130

MEDICAL CERTIFICATE OF HEALTH

RECEIVED

District Health Officer No. 40

District File Number 10-38-228

Date Filed 9-25-1928

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

Wm B. Waters

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

Wm B. Waters

Licensed Embalmer No.

3325

P. O. Address

Vanalia M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

318-94

Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 912
(b) Township Carroll Primary Registration District No. 1232A Registered No. 19
(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

William E. Barnes
(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M

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

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

7. AGE YEARS 67 MONTHS 5 DAYS 14 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 Nov 8 1938 R. L. Marshall Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 7 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ 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:

Acute Myo Carditis Date of onset _____

Post-mortem 120

Other contributory causes of importance:

Acute Glomerular Nephritis May 28
Chronic Nephritis
Cause undetermined, suspect starvation due to gastric

Name of operation _____ Date of _____
What test confirmed diagnosis? Urinalysis Was there an autopsy? No

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. L. Marshall M. D.
(Address) Van Buren St. Louis

