

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.

REC'D APR 7 1939

ORIGINAL

STANDARD CERTIFICATE OF DEATH

State Department of Health
Division of Vital Statistics
STATE OF IOWA

15825
904

1. PLACE OF DEATH
County North State IA Registered No. 904
Township Union or Village _____ or
City _____ No. _____ St. _____ Ward _____

(If death occurred in a hospital or institution give its name instead of street and number)

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.

2. FULL NAME Nancy Jane Barks
(a) Residence. No. Sheridan St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. Single, Married, Widowed, or Divorced (write the word) Widowed

6a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Simon Barks

6. DATE OF BIRTH (month, day, and year) Nov. 13, 1884

7. AGE Years Months Days If less than 1 day, _____ hrs. or _____ mins.
90. 4 0

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

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) Indiana
(State or country) Corydon Harrison Co

13. NAME Wm Conrad

14. BIRTHPLACE (city or town) Indiana
(State or country)

15. MAIDEN NAME Luendia Brieden

16. BIRTHPLACE (city or town) va.
(State or country)

17. INFORMANT Nettie B. Caldwell
(Address) Sheridan Mo.

18. BURIAL, CREMATION, OR REMOVAL
Place Sheridan Date March 15, 1939

19. LICENSED EMBALMER Long & Boyd
(Address) Sheridan Mo.

20. FILED Mar 15, 1939 Mrs. C. H. Bond
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) March 13, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____
_____ 1938 to March 13, 1939
last saw her alive on March 12, 1939. death is said
to have occurred on the date stated above, at _____ m.

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

Chronic Myocarditis Date of onset _____

Contributory causes of importance not related to principal cause: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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 _____

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) Ab Long M. D.
826 (Address) Sheridan

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIANS.

RECEIVED

District Health Officer No. 111

District File Number 29-720

Date Filed APR 3 1939

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY LICENSED EMBALMERS.

Has decedent ever served in military or naval service of the U. S.?..... If so give name of War.....

I..... Licensed Embalmer No..... hereby certify that
the body recorded on the reverse side of this certificate was embalmed by..... L.
No..... or by..... Registered apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

12725-
Do not use this space.

1. PLACE OF DEATH

(a) County North Registration District No. 904
(b) Township Union Primary Registration District No. 6215
(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

(a) Residence, No. Nancy Jane Barnes 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

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 1848
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-13-1884
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
90 4 0
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)

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 1939

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Mar 15, 1939 Mrs O. H. Bond
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-13, 1939

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:

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) A. C. Long, M. D.
(Address) Shenandoah, Mo

