

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.

1. PLACE OF DEATH

(a) County Pemiscot Registration District No. 653
 (b) Townshp _____ Primary Registration District No. 4392 Registered No. _____
 (c) City Steele, Mo (d) Street No. _____ St. _____
 (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 Baby 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			MEDICAL CERTIFICATE OF DEATH	
3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Inf	21. DATE OF DEATH (MONTH, DAY, AND YEAR)	10-24-1939
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____	
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 24, 1939			I last saw h_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 4:10 p.m.	
7. AGE YEARS MONTHS DAYS 10 If LESS than 1 day, _____ hrs. or _____ min.			The principal cause of death and related causes of importance were as follows:	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		Date of onset	
	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) Steele, Mo			Other contributory causes of importance:	
FATHER	13. NAME Carl Barnes		Name of operation _____ Date of _____	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fenley Tenn		What test confirmed diagnosis? _____ Was there an autopsy? _____	
MOTHER	15. MAIDEN NAME Ethel Kifer		23. If death was due to external causes (violence), fill in also the following:	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Evans Ville Ind		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.	
17. INFORMANT (ADDRESS) Carl Barnes Steele, Missouri			Manner of injury _____ Nature of injury _____	
18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Zion DATE 10--25--1939			24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____ (Signed) _____, M. D. (Address) _____	
19. FUNERAL DIRECTOR (NAME) (ADDRESS) German Undt Co Steele, Missouri			20. FILED 11-2 1939 <i>[Signature]</i> Local Registrar.	

200A

STATE OF TEXAS
DEPARTMENT OF HEALTH
DIVISION OF HEALTH SERVICES
5/11/01

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, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

Dr J. O. Vickery (He was the Dr.)
is dead and I
don't know who to get to
78 sign this.

L. G. Morrison

5

(b&h1) 62277-5



Five applications or \$10,000 is the minimum
for EFFICIENCY.

Ten applications or \$20,000 qualifies you
for the HONOR ROLL.

GET THE HABIT - IT PAYS.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

44229

Do not use this space.

1. PLACE OF DEATH

(a) County Pemiscot Registration District No. 65-5
 (b) Township Steele Primary Registration District No. 4392 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (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)
 (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) mf

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, 0 hrs. or 0 min.

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 _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 11-2 1939 L. J. Johnson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-24 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) L. J. Johnson, M. D.

(Address) Steele, Mo.

PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK--THIS

REG-1 X12241

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.

SUPPLEMENTARY