

JAN 12 1940

Registration District No. 79

Primary Registration District No. 61

Registrar's No. 59

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Slater  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rural  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 1/2 years (Specify whether years, months or days)  
In this community 5 1/2 years

3. (a) PRINT FULL NAME Lillie Grace Garnett

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife deceased 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased March 22 - 1884  
(Month) (Day) (Year)

8. AGE: Years 57 Months 9 Days 9 If less than one day hr. X min.

9. Birthplace Near Slater Saline Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation house work

11. Industry or business at home

12. Name John Ruppert

13. Birthplace Germany

14. Maiden name Caroline Ruppert

15. Birthplace New Hartford Saline Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robert Garnett

(b) Address Slater Mo Rt 241

17. (a) Burial (b) Date thereof January 7 - 1940  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Reposals Hosp. Slater

18. (a) Signature of funeral director Wm. H. Salzer

(b) Address Slater Mo

19. (a) 1/11/40 (b) W. M. Little  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline  
(c) City or town Slater  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? X years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31  
year 1939 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from July 3, 1939 to Dec. 31, 1939; that I last saw her alive on Dec. 31, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocarditis Duration 2 wks.

Due to Carcinoma - multilocular cystadenoma right ovary

Due to with generalized metastasis

Other conditions (Include pregnancy within 8 months of death) 49

Major findings: Of operations Carcinoma right ovary

Of autopsy Nose - not examined.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (or) Means of injury \_\_\_\_\_

23. Signature C. A. McJannet (M. D. or other)

Address Slater, Mo. Date signed 1-1-40

AUG 20 1943

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 11/17/40

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.....

*Jones & Selzer*  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *James E. Jones*  
.....  
Licensed Embalmer No. *143*  
P. O. Address *State 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

44782

Do not use this space.

1. PLACE OF DEATH

- (a) County Saline Registration District No. 199  
 (b) Township Cambridge Primary Registration District No. 6037B Registered No. 39  
 (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

- Lillie Grace Barnett  
 (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 7 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 Kentley M. Barnett

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

7. AGE YEARS 37 MONTHS 9 DAYS 9 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

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

MOTHER 15. MAIDEN NAME

MOTHER 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 1940 W. M. Tuttle Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 31, 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) C. G. McRaney M. D.

(Address) Stater

SUPPLEMENTARY

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

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.

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