

FEB 15 1940

State File No.

Registration District No. 561

Primary Registration District No. 3-756-43

Registrar's No. 4

## 1. PLACE OF DEATH:

(a) County Miller  
 (b) City or town Eldon  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
No street address  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution None  
 (Specify whether  
 In this community Period of 1/2 hour  
 years, months or days)

3. (a) PRINT FULL NAME Barbara Luella Greenup3. (b) If veteran, name war. -- 3. (c) Social Security No. --4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if alive -- years7. Birth date of deceased January 27, 1940  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
0 0 0 0 hr. 30 min.9. Birthplace Eldon, Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation --11. Industry or business --12. Name Roscoe K. Greenup13. Birthplace Eldon, Missouri  
(City, town, or county) (State or foreign country)14. Maiden name Willowhees Richardson  
15. Birthplace Bagnell, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature

(b) Address Bagnell, Missouri17. (a) (b) Date thereof (Month) (Day) (Year)  
(Burial, cremation, or removal)(c) Place: burial or cremation Disposed of by18. (a) Signature of funeral director Relatives(b) Address 461519. (a) (Date received local registrar) (b) Belle Haysie  
(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State -- (b) County --  
 (c) City or town --  
 (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.? -- years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 27  
year 1940 hour 11 minute 30 A.M.21. I hereby certify that I attended the deceased from 11:00 to  
11:30, January, 1940, to 19, 1940;  
that I last saw her alive on January 27, 1940,  
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral HemorrhageDue to Forceps deliveryDue to --Other conditions --  
(Include pregnancy within 3 months of death)Major findings:  
Of operations NoneOf autopsy None

## 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?  
NoWhile at work? NO (Specify type of place) (e) Means of injury ---23. Signature E. S. Shelton (M. D. or other) Mo.Address Six South Maple, Date signed 1-30-40

Eldon, Mo.

RECEIVED  
Miller County Health Dep't.  
County File Number 8-40  
Date Filed 2-12-40

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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.**

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

3088  
Do not use this space.

1. PLACE OF DEATH

(a) County Miller Registration District No. 561  
(b) Township \_\_\_\_\_ Primary Registration District No. 4330 Registered No. \_\_\_\_\_  
(c) City Eldon (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 \_\_\_\_\_ mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Barbara Luella Greenup  
(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) 8

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.

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 1-31 1940 Belle Haynes Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-27 1940

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) T. C. Shelton \_\_\_\_\_, M. D.  
(Address) Eldon Mo.

SUPPLEMENTARY

S-3088