

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.

98 FILED MAY 15 1940

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

15898  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County Reynolds 2 Registration District No. 748  
 (b) Township Logan 0 Primary Registration District No. 5982 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 Salina E. Taylor  
 (a) Residence, No. Logan Township 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 <b>F</b>	4. COLOR OR RACE <b>W</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Widow</b>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widow of Wm. Taylor</u> <b>OK</b>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>3-12-1851</u>				
7. AGE	YEARS <b>83</b>	MONTHS <b>10</b>	DAYS <b>10</b>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>Retired</b>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <b>Housewife</b>			
	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) <u>Reynolds CO. MO.</u> <b>0</b>				
FATHER	13. NAME <u>Wm Thomas Barnes</u> <b>0</b>			
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>MO.</u> <b>0</b>				
MOTHER	15. MAIDEN NAME <u>Elizabeth Brooks,</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>MO.</u>			
17. INFORMANT <u>Floy Ashberry</u> (ADDRESS) <u>Ellington, MO.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Ellington, Mo.</u> DATE <u>May 8 1940</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Baker's Newton</u> <u>Ellington Mo.</u>				
20. FILED <u>May 9 1940</u> <u>Essie Evans</u> Local Registrar.				

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 8 1940  
 22. I HEREBY CERTIFY, That I attended deceased from March 25, 1930, to May 3, 1940, 1940.  
 I last saw her alive on March 25, 1940. Death is said to have occurred on the date stated above, at 7:30 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Aortic Regurgitation and Chronic Brights Disease.  
 Other contributory causes of importance: 121  
 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. J. Burg, M. D.  
 (Address) Ellington, Mo.

Date of onset	<u>1 yr.</u>
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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.

**RECEIVED**

District Health Officer No. 5,

District File Number 540579

Date Filed 5/4/40

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15-8987

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 748

Primary Registration District No. 3782

Registrar's No.

1. PLACE OF DEATH:

(a) County Reynolds  
(b) City or town Jan  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.  
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Salina E. Taylor

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wed

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

7. Birth date of deceased June 28 1894  
(Month) (Day) (Year)

8. AGE: Years 83 Months 10 Days 10 If less than one day hr min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

12. Name.

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name.

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant.

(b) Address.

17. (a) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) June 28 (Date received local registrar) (b) Essie Evans (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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH. Month May day 8 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death.

Due to. Due to. Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations. Of autopsy.

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?

(Specify type of place) While at work? (e) Means of injury.

23. Signature J. F. Buegg (M. D. or other) Address Ellington Mo. Date signed

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

