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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 days
(Specify whether years, months or days)
In this community 20 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1121 West State.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1940 hour 3 minute 15 P M.
21. I hereby certify that I attended the deceased from 7/1/40
19____ to 7/23/40 1940
that I last saw him alive on 7/23 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction
2 - Pelvic abscess

Due to Hysterectomy & Chl. Salpingitis, w/o operated on 72+ times and 2 Colectomies & high tubes removed. She developed an infection & intestinal obstruction
Major findings: Fibroid 2 - Salpingitis
Of operation _____
Of 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?
984
While at work? _____ (Specify type of place)
(e) Means of injury _____
Signature Italawze (M. D. or other) _____
Address Medical Arts Bldg Date signed 7/28/40

8. (a) PRINT FULL NAME Lemma Elizabeth Barker 626

8. (b) If veteran, name war No 8. (c) Social Security No. None

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

6. (b) Name of husband or wife Noel E. Barker 6. (c) Age of husband or wife if alive. 38 years

7. Birth date of deceased Dec. 27 1909
(Month) (Day) (Year)

8. AGE: Years 30 Months 6 Days 26
If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER { 12. Name George D. Pinkston
13. Birthplace Marshall County Miss
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ida Lemons
15. Birthplace Marshall County Miss
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Pinkston
(b) Address 1121 West State, Springfield.

17. (a) Burial (b) Date thereof 7-25-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cemetery
Dunn Funeral Home

18. (a) Signature of funeral director _____
(b) Address 629 W. Walnut, Springfield, Mo

19. (a) July 25, 1940 W. E. Hardley
(Date received by local registrar) (Registrar's signature)

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

7-39
X21492

127A

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 Hoyd W. Fox

Licensed Embalmer No. 2910

P. O. Address 629 W. Walnut

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.

X

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 25218

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. _____

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

1. PLACE OF BIRTH:

(a) County Greene
(b) City or town Springfield
(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 _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Lemna Elizabeth Barker

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

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

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 30 Months 6 Days 26 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) 8-17-40 (Date received local registrar) (b) W. E. Handley (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.

20. DATE OF DEATH: Month July day 23 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal Obstruction
Pelvic abscess

Due to Splenectomy & Salpingitis

Due to was operated on 2 June

Other conditions (include pregnancy within 3 months of death)
loop of cocoon and both tubes were removed

Major findings: she developed an infection and Intestinal Obstruction
Fibrosis. (2) Salpingitis

22. In definite history as to _____

(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)
(e) Means of injury _____

Signature H. A. Lowe (M. D. or other) _____
Date signed _____

SUPPLEMENTARY 542

PHYSICIAN certifying the cause to which death should be charged statistically.

