No. 2
1-10-3
-17-36

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

25828

State File No. 10

AUG 3 1940

Registration District No. 55

Primary Registration District No. 6262

Registrar's No. ~~33~~ 33

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

1. PLACE OF DEATH:

(a) County New Madrid Anderson Tp

(b) City or town Tallapoosa, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: at Home
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Near Parma in Tallapoosa
(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.

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3. (a) PRINT FULL NAME Carolyn Joyce Barrett

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

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

6. (b) Name of ~~husband~~ father or wife Charley Barrett 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased October (Month) 14 (Day) 1939 (Year)

8. AGE: Years ____ Months 9 Days 19 If less than one day ____ hr. ____ min.

9. Birthplace Tallapoosa, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation — 1

11. Industry or business —

FATHER
12. Name Charley Barrett 1
13. Birthplace Tennessee (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Cora Elizabeth Wells
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Charley Barrett
(b) Address Tallapoosa, Mo.

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof July 4 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Gilliard

18. (a) Signature of funeral director Landess Funeral Home
(b) Address Campbell, Missouri

19. (a) ____ (Date received local registrar) (b) T. D. Mannina (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1940 hour 4 minute 40 P.M.

21. I hereby certify that I attended the deceased from June 16 1940 ~~July 3~~, 19__, to July 3, 1940; that I last saw ____ alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Convulsions	1 hour
Acute Ileo Colitis	6/14/40
Due to	
Due to	
Other conditions Whooping Cough (Include pregnancy within 3 months of death)	7 wks

Major findings:
Of operations ____
Of autopsy ____

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

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

23. Signature John D. Van Cleve (M. D. or other) 1
Address Malden Mo Date signed 7/4/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2,
District File Number 840-125
Date Filed 8/1/40

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.....

....., 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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25828

Registration District No. 53-

Primary Registration District No. 6262

Registrar's No.

1. PLACE OF DEATH:
(a) County New Madrid
(b) ~~City or town~~ Anderson T. P.
(If outside city or town limits, write "RURAL" and name of township)
(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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME Carolyn Joyce Barrett
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 —
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive year
7. Birth date of deceased Oct (Month) 14 (Day) 1939 (Year)

8. AGE: Years | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) July 7, 1940 (Date received local registrar) (b) M. W. Mumma (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1940 hour 1 minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY