

FILED SEP 24 1940

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

Do not use this space.

29855

1. PLACE OF DEATH

County ShannonRegistration District No. 823Township WinonaPrimary Registration District No. 607City 1030 Eva Barnett(No. 1030)St. Ward

2. FULL NAME

(a) Residence, No. 1030
(Usual place of abode)St. Ward

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)married5A. IF MARRIED, WIDOWED, OR DIVORCED,
HUSBAND OF
(OR) WIFE OFJ. L. Barnett

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

Sept 27, 1868

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, ... hrs.
or min.71916

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.House9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Bradley Co Tenn

FATHER

13. NAME

Sam M. Spadden14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Tenn

MOTHER

15. MAIDEN NAME

Mona Neal16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Tenn17. INFORMANT
(ADDRESS)Eva Barnett
Winona Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Falling Springs

DATE

July 15, 194019. UNDERTAKER
(ADDRESS)C. M. Fletcher
Don Owen Mo20. FILED 7-13-, 1940Frank H. de MD
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

July 13, 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 7:00 A. M.

The principal cause of death and related causes of importance were as follows:

Myocarditis

Date of onset

Other contributory causes of importance:

Interstitial
Nephritis12
yrs.

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)

Frank H. de MD

M. D.

(Address)

Examiner Mo

RECEIVED

District Health Officer No. 5,

District File Number

840898

Date Filed

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29855-**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **823**

Primary Registration District No. **6074**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Shannon**
(b) City or town **Winona, Mo.**
(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

In this community
years, months or days)

3. (a) PRINT FULL NAME **Eva Barrett**

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.

6. (b) Name of husband or wife

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

7. Birth date of deceased.

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

71

9

16

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)

(b) Date thereof

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

7-15-40

(b)

Frank Hyde MD

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Shannon**
(c) City or town **Winona**
(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 **July** day **13**
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

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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)

(e) Means of injury

23. Signature

Address

Frank Hyde

(M, D. or other)

Assigned

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

SUPPLEMENTAL

