

AUG 2 1940

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

29862
Do not use this space.

1. PLACE OF DEATH

(a) County Shelby Registration District No. 831

(b) Township Black Creek Primary Registration District No. 4504

(c) City Shelbyville (d) Street No. _____ (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 Lillian Jewell Barney

(a) Residence, No. _____ (Usual place of abode, if no street address, write county or city) St. Mo. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Oscar Barney

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 14 1879

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>60</u>	<u>6</u>	<u>17</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

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) Shelbyville Mo.

FATHER

13. NAME James W. Garrison

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelby Co. Mo.

MOTHER

15. MAIDEN NAME Fannie Settle

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelby Co. Mo.

17. INFORMANT (ADDRESS) Oscar Barney
Shelbyville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE D. O. F. Cemetery DATE July 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. P. Thompson
Shelbyville, Mo.

20. FILED July 2 1940 Pearl Goe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Apr. 28 1940 to July 1 1940

I last saw her alive on June 28 1940 Death is said to have occurred on the date stated above, at 9:15 AM.

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

Coronary occlusion

Date of onset Apr 28 1940

Other contributory causes of importance: 9410

Name of operation None Date of _____

What test confirmed diagnosis? Clinical Was there an autopsy? No

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? No

If so, specify _____

(Signed) H. J. Frazier, M. D.

(Address) Shelbyville Mo.

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.

RECEIVED
Director Health Officer No. 10
7-14-47
JUL 24 1940

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 E. P. Thompson
Licensed Embalmer No. 1632
P. O. Address Shelbyville

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29862**

Registration District No. **831**

Primary Registration District No. **43-04**

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County... **Shelby**
 (b) City or town... **Shelbyville**
(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)

2. USUAL RESIDENCE OF DECEASED:
 (a) State... **Mo** (b) County... **Shelby**
 (c) City or town... **Shelbyville**
(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 **William Jewell Carnes**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 4. DATE OF DEATH: Month **July** Day **1**
 year _____ hour _____ minute _____ M.

4. Sex **7** 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)

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 _____

8. AGE: Years **60** Months **6** Days **17** If less than one day _____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 10. Usual occupation _____

11. Industry or business _____
MOTHER { 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)

Major findings:
 Of operations _____
 Of autopsy _____

16. (a) Informant _____ (b) Address _____
 17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

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 _____

18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) **July 2** (b) **40 Pearl Gae**
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

 Underline the cause to which death should be charged statistically.

