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

39964
Do not use this space.

FILED DEC 10 1940

1. PLACE OF DEATH
(a) County Stone — Registration District No. 845 — V
(b) Township Ruth — Primary Registration District No. 6108 — 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 Columbus Wm Barnhart
(a) Residence, No. Reeds Spring Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

6A. IF MARRIED, WIDOWED, OR DIVORCED — ~~HUSBAND OF~~ (OR) WIFE OF Mollie Barnhart

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 2 1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	86	10	1	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. None
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) Webster Co. Mo

FATHER
13. NAME Robt Barnhart
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

MOTHER
15. MAIDEN NAME Don't Know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

17. INFORMANT (ADDRESS) Louis Barnhart Reeds Spring Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Evergreen Cemetery DATE Nov 5 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs Hettie Stults Reeds Spring Mo

20. FILED ....., 19..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 3 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct 1 1940 to Nov 3 1940
I last saw him alive on Nov 3 1940 Death is said to have occurred on the date stated above, at 10:15 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hydrothorax	July 1940
Cirrhosis of Kidneys	1936
Mitral Insufficiency	1936

Other contributory causes of importance: None

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? No
If so, specify .....

(Signed) L D Shumate, M. D.
(Address) Reeds Spring Mo

(Licensed Embalmer's Statement on Reverse Side)

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.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED
District Health Officer No. 6,
District File Number 1140-2949
Date Filed DEC 6 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.....

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.

S. No. 2B
I—2-21-40
I X22859

Howard Moore

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. 39964

Registration District No. 845 — Primary Registration District No. 6108 — Registrar's No.

1. PLACE OF DEATH
(a) County Stone
(b) ~~City or town~~ Ruth R. 1, P. O.
(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 (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 Columbus Wm Barnhart
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
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 86 | Months 10 | Days 1 | 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
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

FATHER
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) 11/3/40 (Date received local registrar) (b) L. S. Stewmate (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 3
year 1940 hour 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 L. S. Stewmate (M. D. or other)
Address Reeds Springs Date signed

1940
5-39964