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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

7880

State File No. ____

FILED MAR 15 1943

Registration District No. 5

Primary Registration District No. 6162

Registrar's No. 5

1. PLACE OF DEATH:
(a) County Stone
(b) City or town Ruth Tp Rural
(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 Mo (b) County Stone
(c) City or town Ruth Tp Rural
(If outside city or town limits, write "RURAL")
(d) Street No. ____
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No) /
If yes, name country ____

3. (a) PRINT FULL NAME Troy Edward Barnes
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 Single
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Nov. (Month) 18 (Day) 1942 (Year)

8. AGE: Years ____ | Months 3 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Stone Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation none
11. Industry or business ____
FATHER
12. Name Russell Barnes
13. Birthplace ____ Mo (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Golda Horn
15. Birthplace ____ Mo (City, town, or county) (State or foreign country)
16. (a) Informant Russell Barnes
(b) Address Reeds Spring Mo
17. (a) Yocum Pond (Burial, cremation, or removal) (b) Date thereof 2/14/43 (Month) (Day) (Year)
(c) Place: burial or cremation Yocum Pond
18. (a) Signature of funeral director Foster Barnes (Acting)
(b) Address ____
19. (a) ____ (Date received local registrar) (b) Eulage Arnold (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 13 year 1943 hour 2:30 minute P. M.
21. I hereby certify that I attended the deceased from Feb 7, 1943 to Feb 13, 1943 that I last saw him alive on Feb 13, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	6 days
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 Sherrill (M.D. or other) MD
Address Reeds Spring Mo Date signed 2/14/43

1292

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 343-331
Date Filed MAR 6 1943

MAR 17 1943

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 wi
the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—8-21-41
X29286

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. 7880

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County Stone
(b) City or town Rural
(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 Mo (b) County Stone
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Troy E. Barnes
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 S
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 10 (Month) (Day) 1867 (Year)
8. AGE: Years — Months 5 Days _____ If less than one day _____ hrs. _____ min.
9. Birthplace _____ (City, town, or county) Mo (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)
MOTHER
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) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 13
year 1943 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: Bronchial Pneumonia	6 days
Due to: Exposure	
Due to: no measles or whooping cough that I know of	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? _____ (c) Means of injury _____

23. Signature L.S. Shumate (M. D. or coroner)
Address _____ Date signed _____

SUPPLEMENTARY
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