

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26291

State File No. \_\_\_\_\_

FILED JUL 17 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 6134

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Shannon  
(b) City or town Rural Lowassie, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution NO (Specify whether  
In this community 5 Years  
years, months or days)

3. (a) PRINT FULL NAME Eileen Barnes

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

4. Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Emeral Barnes 6. (c) Age of husband or wife if alive 33 years  
7. Birth date of deceased May 27th 1910  
(Month) (Day) (Year)

8. AGE: Years 33 Months - Days 27 If less than one day hr. min.

9. Birthplace Shannon Co., Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name J.W. Freewatt  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Hannah Leak  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Emeral Barnes

(b) Address Lowassie, Mo

17. (a) Burial (b) Date thereof 6/26th 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bathel Chapel

18. (a) Signature of funeral director John F. Duncan

(b) Address Mountain View, MO.

19. (a) 6-28-43 (b) Frank Hyde MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon  
(c) City or town Lowassie, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24th  
year 1943 hour 7 minute 8 A. M.

21. I hereby certify that I attended the deceased from 6-22, 1943, to 6-24, 1943  
that I last saw her alive on 6-21, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis Duration 10 days

Due to infection from kidney  
nephritis was done  
Due to no previous

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W.T. Eudy (M. D. or other) \_\_\_\_\_  
Address Commerce Mo. Date signed 6-26-43

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

RECEIVED

District Health Officer No. 5,

District File Number 743456

Date Filed 7-15-48

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. 2516

P. O. Address Mt. View

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to enter the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 336

Primary Registration District No. 6134

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Shannon  
(b) City or town Rural Pike Creek Exp.  
(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

Eileen Borne

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 m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years

7. Birth date of deceased may 27  
(Month) (Day) (Year)

8. AGE: Years 33 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ 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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June  
year 1943 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I have seen him alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death myocardial

Due to 13363  
Due to 4-5-43  
Other conditions hypertension left  
(Include pregnancy within 3 months of death)  
Major findings: Myocardial infarction  
Of operations Myocardial infarction

Of autopsy \_\_\_\_\_

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) (c) Means of injury \_\_\_\_\_

23. Signature V. K. Eudy (M. D. or other) \_\_\_\_\_  
Address Cincinnati, Mo. Date signed 7-22-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-26291