

FILED MAR 13 1945

Registration District No.

Primary Registration District No.

4450

Registrar's No. 2033

1. PLACE OF DEATH:

(a) County Ripley
(b) City or town Doniphan
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution William D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks (Specify whether
In this community 50 years years, months or days)

3. (a) PRINT FULL NAME

MARTHA LOUISE BARFIELD

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Chas S Barfield 6. (c) Age of husband or wife If alive 10 years (Day) 18 (Year) 57
7. Birth date of deceased July (Month) 10 (Day) 18 (Year) 57

8. AGE:

Years

Months

Days

If less than one day

87 8 2

hr. min.

9. Birthplace

Paducah Ky
(City, town, or county) (State or foreign country)

10. Usual occupation

House Keeper

11. Industry or business

12. Name John Mc Kiney
13. Birthplace Paducah Ky
(City, town, or county) (State or foreign country)
14. Maiden name Slice
15. Birthplace Paducah Ky
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Chas Woodard

(b) Address Naylor Mo

17. (a) Burial (b) Date thereof Mar 14 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairdale Cem

18. (a) Signature of funeral director Minnie Lish

(b) Address Naylor Mo

19. (a) 3-15-45 (b) E O Johnston
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ripley
(c) City or town Naylor
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 12
year 1945 hour 9 minute AM

21. I hereby certify that I attended the deceased from Feb 18-45
19 March-12 19 45
that I last saw her alive on March-12 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death Hepatic Pneumonia
Fractured hips
Due to Fractured hips
Due to

Other conditions ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
(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) accident
(b) Date of occurrence Feb-17-45
(c) Where did injury occur? Naylor Ripley Mo
(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)
(e) Means of injury

23. Signature E O Johnston (M. D. or other)
Address Doniphan Mo Date signed 3-15-45

678

(Licensed Embalmer's Statement on Reverse Side)

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

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. 4119

P. O. Address Taylor Mo

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, 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. April

Registration District No. 351

Primary Registration District No. 4450

Registrar's No. 2083

1. PLACE OF DEATH:

(a) County Ripley
(b) City or town Doniphan
(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 Martha L. Barfield

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 W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 10
(Month) (Day) (Year)

8. AGE: Years 87 Months 8 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 March Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
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 Fall in hand of lance on farm

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

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(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 Doniphan (M. D. or other)

Address Doniphan Mo Date signed 3-26-45

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

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

Duration

PHYSICIAN

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

10498

JUN 26 1945