

**FILED JUL 18 1946**

Registration District No. **273**

Primary Registration District No. **3047**

Registrar's No. **59**

1. PLACE OF DEATH:  
(a) County **Newton**  
(b) City or town **Neosho**  
(c) Name of hospital or institution: **Spales Memorial**  
(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 **Newton**  
(c) City or town **Granby Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Ella Barnard**  
3. (b) If veteran, name war **L**  
3. (c) Social Security No. **L**

20. DATE OF DEATH: Month **JULY** day **8**  
year **1946** hour **11** minute **50 A.M.**

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Aug. 1870**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **MAY 24** 19**46** to **JULY 8** 19**46**  
that I last saw her alive on **JULY 8** 19**46**  
and that death occurred on the date and hour stated above.

8. AGE: Years **75** Months **11** Days **2** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Carcinoma left ear and neck**  
Due to **Not known**  
Duration **6 MO**

9. Birthplace **Granby Mo.**  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Other conditions **None**  
(Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**

Major findings: Of operations **None**  
Of autopsy **None**

11. Industry or business \_\_\_\_\_  
12. Name **Daniel Shipman**  
13. Birthplace **Neosho**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Betty Anderson**  
15. Birthplace **Neosho**  
(City, town, or county) (State or foreign country)

ADDITIONAL INFORMATION  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Edward Barnard**  
(b) Address **Granby Mo.**  
17. (a) **Burial** (b) Date thereof **July 10 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Granby Mo.**

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) \_\_\_\_\_  
Means of injury \_\_\_\_\_

18. (a) Signature of funeral director **D. C. Gidd**  
(b) Address **Granby Mo.**  
19. (a) **July 8, 1946** (b) **Melvin C. Borman**  
(Date received local registrar) (Registrar's signature)

23. Signature **L. J. Taylor** (M. D. Registrar)  
Address: **113 W. Hickory Neosho Mo.** Date signed **8 July 46**

**RECEIVED**

District Health Officer No. ....  
District File Number 7-46-97 .....  
Date Filed 7-17-46 .....

**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

*Margaret Culver*

License/Embalmer No.

*4389*

P. O. Address

*Cosvill*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Aug  
Registrar's No. 598

Registration District No. 245

Primary Registration District No. 3047

1. PLACE OF DEATH: Newton  
(a) County newark  
(b) City or town  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days)

3. (a) PRINT FULL NAME Ella Barnard  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 \_\_\_\_\_ year

7. Birth date of deceased: Aug 6  
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days \_\_\_\_\_ (Less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 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) \_\_\_\_\_ (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)

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 CERTIFICATE  
20. DATE OF DEATH: Month \_\_\_\_\_ year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Carcinoma left ear  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
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) \_\_\_\_\_  
(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. H. Hickey (M. D. or other) \_\_\_\_\_  
Address 13 W. Hickey, Newark, Mo. Date signed 25 July 46

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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