

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

V. S. No. 2.

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

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.

PLACE OF DEATH Andrew
 County Rothschild Registration-District No. 15 File No. 37
 Township Empire or Village 5015 Primary Registration District No. 5015 Registered No. 73
 City _____ (NO. _____) St. _____ Ward _____
 FULL NAME Eliza Jane Barber [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE W.P.V. SINGLE Yes MARRIED Yes WIDOWED OR DIVORCED Yes (Write the word)

DATE OF BIRTH April 22, 1837
 (Month) (Day) (Year)

AGE 76 yrs. 7 mos. 25 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work House wife
 (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Shelby Co Ky.

PARENTS
 NAME OF FATHER Allen Sloan
 BIRTHPLACE OF FATHER Indiana
 MAIDEN NAME OF MOTHER Blackmore
 BIRTHPLACE OF MOTHER Indiana

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 16, 1915
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1912, to Dec 16, 1915, that I last saw her alive on Aug 1, 1915, and that death occurred, on the date stated above, at 3:45 m.

The CAUSE OF DEATH* was as follows:
Organic Heart, Pulmonary Infarction
92A
95B (Duration) 3 yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.
 Signed Walter C. Myers M. D. (Address) Savannah

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Union Star DATE OF BURIAL Dec 17, 1915
 UNDERTAKER H. S. & I. E. Cole ADDRESS Spring City

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Walter C. Myers
 (ADDRESS) Savannah Mo
 Filed Jan 1, 1916 E. C. Jappies REGISTRAR

MISSOURI STATE BOARD OF HEALTH
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PLACE OF DEATH
Andover, Empire

County *Empire* Registration District No. *13* File No. _____
Township _____ Registered No. *23*
or _____
Village _____ Primary Registration District No. *5018*
or _____ St.: _____ Ward) _____
City _____ (NO. _____) _____
[If death occurred in a hospital or institution give its NAME instead of street and number]

FULL NAME *Eliza Jane Barber*

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
Female *White*
SINGLE _____ MARRIED _____
WIDOWED _____ OR DIVORCED _____
(If file the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____
AGE _____
IF LESS than
1 day, _____ hrs.
or _____ min.?

OCCUPATION _____
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
None

BIRTHPLACE _____
(City or town, State or foreign country)

NAME OF FATHER _____

BIRTHPLACE OF FATHER _____
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER _____
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____

(ADDRESS) _____

Filed _____ 191____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Dec 16*
(Month) _____ (Day) _____ (Year) _____
I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h. _____ alive on _____, 191____,
and that death occurred, on the date stated above, at _____
The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)
(Signed) _____, 191____ (Address) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Duration) _____ yrs. _____ mos. _____ ds.
M. D. _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL
Union Star
DATE OF BURIAL *Dec 17* 191____

UNDERTAKER
W. J. & E. Cole
ADDRESS
Union Star

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
V. S. No. 2
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