

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

Do not use this space. **5727**

**1. PLACE OF DEATH**

County Cape Girardeau, Mo. Registration District No. 125  
 Township Cape Girardeau, Mo. Primary Registration District No. 3007  
 City Cape Girardeau, Mo. St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 39  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mrs. Emily Barnes  
 (a) Residence, No. Marble City, Mo. Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 19, 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
79 8 18

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Cash, Ky.  
 (STATE OR COUNTRY) Kentucky

10. NAME OF FATHER James Oster

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky  
 (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Elizabeth

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kentucky  
 (STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs. Nellie Hummel  
 (Address) Cape Girardeau, Mo.

15. FILED 78-29 W.C. Kaempfer REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 7 1929

17. I HEREBY CERTIFY That I attended deceased from 2/5-1929 to 2/7-1929 that I last saw him alive on 2/5-1929 and that death occurred, on the date stated above, at 10:50 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cancer of Stomach  
4 1/2 yrs. (duration)

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

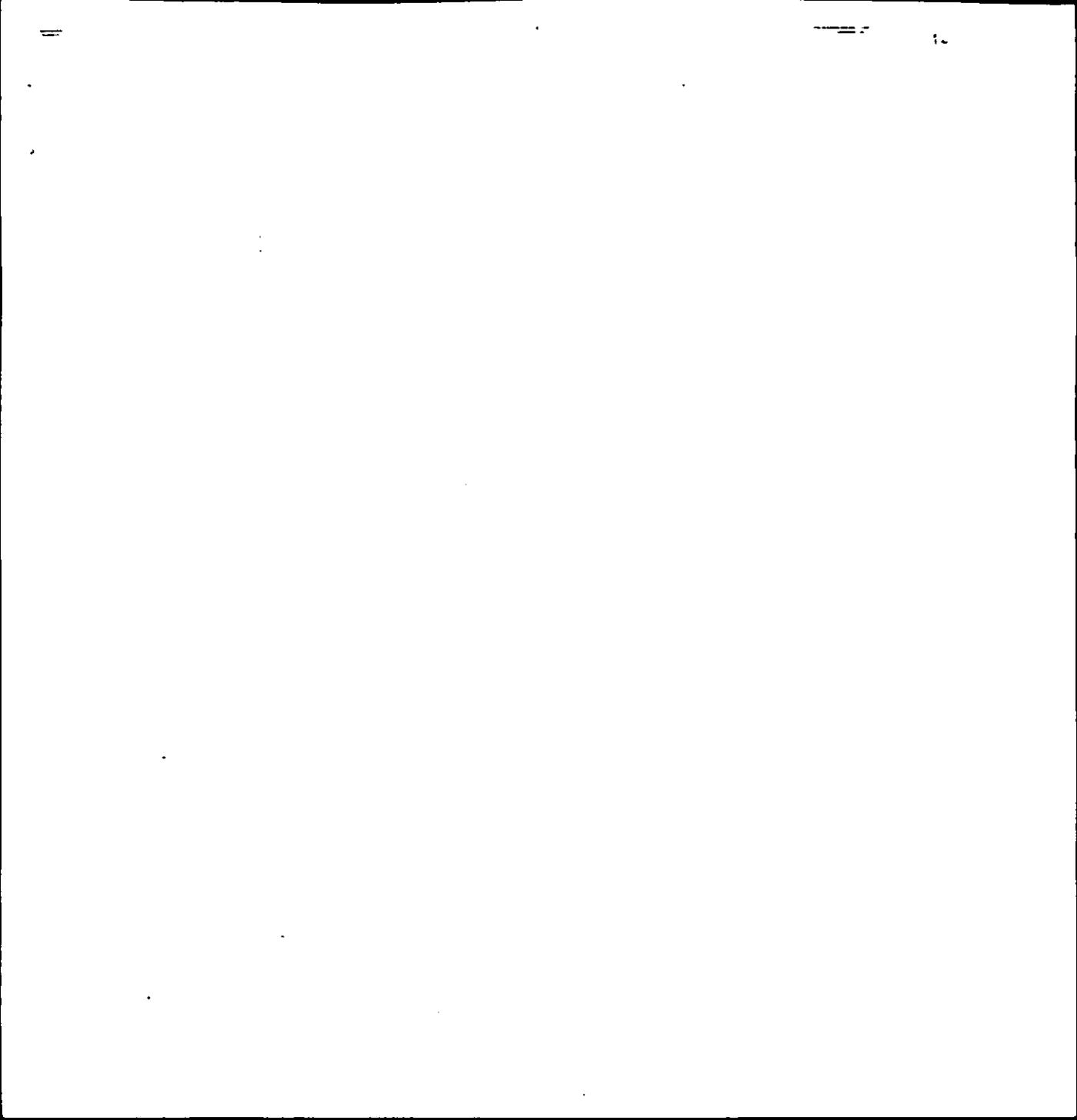
20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Stomach Symptoms  
 (Signed) Al Bunkopf, M. D.  
 (Address) Cape Girardeau, Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cash, Ky. DATE OF BURIAL 2-10 1929

20. UNDERTAKER Al Bunkopf ADDRESS 536 Broadway



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Cape Girardeau  
Township.....  
City..... (No. .... St. .... Ward)

Registration District No. 125  
Primary Registration District No. 3009

File No.....  
Registered No. 39

**2. FULL NAME**

Mrs Emely Barnes

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 19, 1846

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
<u>82</u>		<u>8</u>	<u>18</u>	

**8. OCCUPATION OF DECEASED**

- (a) Trade, profession, or particular kind of work..... (duration) ..... yrs. .... mos. .... ds.  
(b) General nature of industry, business, or establishment in which employed (or employer)..... (duration) ..... yrs. .... mos. .... ds.  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

**PARENTS**

10. NAME OF FATHER.....  
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER.....  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT..... (Address)

15. FILED 4-6-29 W Kaempfer REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 7 1929 19

17. I HEREBY CERTIFY That I attended deceased from....., 19..... to....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

....., 19..... (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL.....

20. UNDERTAKER..... ADDRESS.....

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

2025-5