

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

Do not use this space.

37568

**1. PLACE OF DEATH**

County Lawrence  
Township Mt Vernon  
City Mt Vernon (No. ....)

Registration District No. 470  
Primary Registration District No. 4283

File No. ....  
Registered No. 54  
St. .... Ward

**2. FULL NAME**

Minnie Barker Owens

(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 25 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12-1867

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .... hrs. or .... min.
<u>62</u>	<u>8</u>	<u>28</u>	<u>28</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed (or employer) X  
(c) Name of employer

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

10. NAME OF FATHER Sam Barker

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

12. MAIDEN NAME OF MOTHER Resina Fuller

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

14. INFORMANT A D Barker  
(Address) Mt Vernon Mo

15. FILED 12/9/29 19 11 Fuller  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 11<sup>th</sup> 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 to Nov 10 1929  
that I last saw him alive on Nov 10, 1929 and that death occurred, on the date stated above, at 1 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Suppurative Intestinal Obstruction  
(duration) .... yrs. .... mos. 8 da.

**CONTRIBUTORY (SECONDARY)**

(duration) .... yrs. .... mos. .... da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, .....

DID AN OPERATION PRECEDE DEATH? NO DATE OF .....

WAS THERE AN AUTOPSY? NO

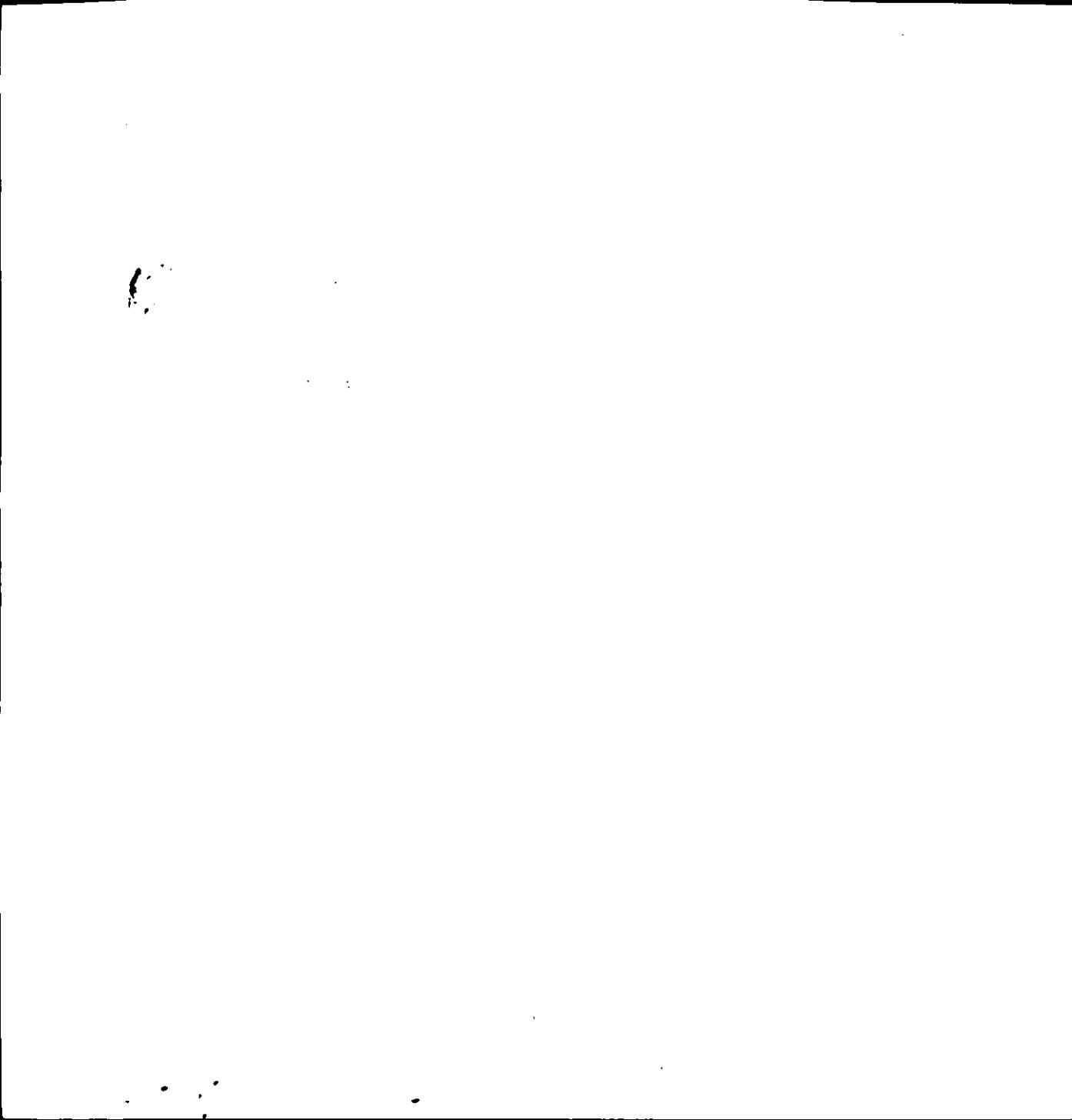
**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) W. S. Fullerton, M. D.  
, 10 (Address) Mt Vernon

\*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 Mt Vernon City Cem. DATE OF BURIAL Nov 12 1929

20. UNDERTAKER Geo B. Orr ADDRESS Mt Vernon Mo



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Lawrence Registration District No. 470 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 4283 Registered No. 34  
 City mt Vernon (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Missie Parker Greene  
 (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

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

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

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

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. Jan 10, 1950 W J Fulton  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 11 1949

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:  
Intestinal obstruction  
cause unknown  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) 11862  
 (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 \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

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

5-1000-5