

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.

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

REC'D JAN 6 1939

43961  
Do not use this space.

1. PLACE OF DEATH

(a) County Hodaway 2 Registration District No. 630  
(b) Township Proctor Primary Registration District No. 4380 Registered No. \_\_\_\_\_  
(c) City Skidmore Mo (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
1230 Mrs Margaret Barrett  
(Usual place of abode, if no street address, write county or city)

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 Robert Barrett Sr.  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 15-1864  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
74 74 8 11  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bellvue 5  
St. Louis

FATHER 13. NAME John Sherrard

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland 4

MOTHER 15. MAIDEN NAME Margaret Brookshire

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chilmark 5

17. INFORMANT Edwood Bassett  
(ADDRESS) Maryville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Skidmore Cemetery DATE Dec 29 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Campbell Funeral Home  
957 South Main Maryville Mo

20. FILED Dec 29 1938 Dr. J. C. Manning  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 26 1938

22. I HEREBY CERTIFY, That I attended deceased from 12/13, 1938 to 12/26, 1938.  
I last saw him alive on 12/26, 1938. Death is said to have occurred on the date stated above, at 5 P. m.  
The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage  
Branches pneumonia  
Date of onset 12/23/38  
12/23/38

Other contributory causes of importance: Hypertension  
Glaucoma

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? NO  
If so, specify \_\_\_\_\_ (Signed) Dr. J. C. Manning M. D.  
Dr. J. C. Manning

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,

*W. Dean Campbell*

, or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*W. Dean Campbell*

Licensed Embalmer No.

*3630*

P. O. Address \_\_\_\_\_

**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, above space should be left blank.**