REC'D MAR 15 1939

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

5884
Do not use this space.

1. PLACE OF DEATH
(a) County: Boone
(b) Township: Bourbon
(c) City:
(d) Street No.: St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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.

Registration District No.: 79
Primary Registration District No.: 5116
Registered No.:

16

2. PRINT FULL NAME: Elis Barnes
(a) Residence, No.: St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
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): July 20, 1849
7. AGE: Years 89 | Months 6 | Days 8 | If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.: Retired
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): Boone Co. Mo.

FATHER
13. NAME: John Barnes
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): don't know

MOTHER
15. MAIDEN NAME: Mary Ann Jones
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): don't know

17. INFORMANT (ADDRESS): Barney Barnes, Sturgeon, Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Far West DATE: Mar. 2, 1939
19. FUNERAL DIRECTOR (ADDRESS): Barnes & Booth, Sturgeon, Mo.
20. FILED: Mar. 2, 1939 A E Booth, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Feb. 28, 1939
22. I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1939, to Feb. 24, 1939
I last saw him alive on Feb. 24, 1939. Death is said to have occurred on the date stated above, at 11 P. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchial Pneumonia	
Hypostatic Pneumonia	

Other contributory causes of importance:

Name of operation: none Date of:
What test confirmed diagnosis? Sym 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) [illegible], M. D.
(Address) Centralia Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

1948

11 P.M.
Feb. 28

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

3884
Do not use this space.

1. PLACE OF DEATH
(a) County: Boone — Registration District No.: 79
(b) Township: Bourbon — Primary Registration District No.: 5116 — Registered No.:
(c) City: — (d) Street No.: St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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: Elis Barnes
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
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)

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
89	6	8	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 28 1939

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19
I last saw h alive on 19 Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Fracture of hip	
Hypostatic Pneumonia	

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) T. M. Turner, M. D.
(Address) Centralia Mo.

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.