

FILED JUL 17 1940 STANDARD CERTIFICATE OF DEATH

State File No.

22061

Registration District No. 428

Primary Registration District No. 5581

Registrar's No.

11

1. PLACE OF DEATH:

- (a) County Johnson
 (b) City or town Chelhowee (Rural)
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2In this community 84 yrs.
years, months or days (Specify whether)3. (a) PRINT FULL NAME Tennessee Barthick

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow6. (b) Name of husband or wife Clay Barthick 6. (c) Age of husband or wife if alive X years7. Birth date of deceased Oct - 16 - 1852
(Month) (Day) (Year)8. AGE: Years 87 Months 8 Days 0 If less than one day hr. min.9. Birthplace Tenn.
(City, town, or county) (State or foreign country)10. Usual occupation Housekeeper

11. Industry or business

12. Name James Kirkpatrick18. Birthplace Tenn.
(City, town, or county) (State or foreign country)14. Maiden name Ollie Ray15. Birthplace Tenn.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature T. H. Barthick(b) Address Chelhowee, Mo17. (a) Burial (b) Date thereof June 18 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Sunset Hill18. (a) Signature of funeral director Queeney Phillips(b) Address Warrensburg, Mo19. (a) 6/19/40 (b) O. H. Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson(c) City or town Chelhowee (Rural)
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1940 hour 4:30 minute PM21. I hereby certify that I attended the deceased from Oct - 1937
1937, to 6-16-40
6-14-37that I last saw her alive on 6-14-37, 1937
and that death occurred on the date and hour stated above.Immediate cause of death Bright's Disease /
Duration ?

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (e) Means of injury

23. Signature W. F. Manning (M. D. or other) M.D.Address Warrensburg, Mo Date signed 6-17-40

JUN 9 1957

RECEIVED
District Health Officer No. 8
Service File Number 7-15-40
Date Filed

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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 22061

Registration District No. 426

Primary Registration District No. 5381

Registrar's No. 11

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

ROWENA MOORE

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Chilhowee T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Tennessee Berthier

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race _____ 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 87 Months 8 Days 0 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL.")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bright's Disease
(Chronic)
Due to cause not known
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 131

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. F. McKenney M.D. or other) _____
Address Harleburg Va Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

