S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17947

Registration District No. 170 Primary Registration District No. 5632 Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town RURAL OSAGE TWP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DRY NOB
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community ALWAYS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. ____
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME NANCY JANE STARNES
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased JAN (Month) 10 (Day) 1857 (Year)

8. AGE: Years 90 Months 4 Days 19 If less than one day ____ hr. ____ min.

9. Birthplace LACLEDE Co (City, town, or county) MO. (State or foreign country)
10. Usual occupation FARMER'S WIDOW
11. Industry or business ____
FATHER
12. Name HEZICA BARNES
13. Birthplace ____ (City, town, or county) TENN. (State or foreign country)
MOTHER
14. Maiden name MARY ANN BENCH
15. Birthplace LACLEDE Co. (City, town, or county) MO (State or foreign country)
16. (a) Informant Nellie McNeal
(b) Address Dry Nob Mo.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-31-47 (Month) (Day) (Year)
(c) Place: burial or cremation OAKLAND CEM.
18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO
19. (a) 6-7-1947 (Date received local registrar) (b) Ora Frankenberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 29 year 1947 hour 8 minute 50 A.M.
21. I hereby certify that I attended the deceased from 2-May 1947 to 20-May 1947 that I last saw her alive on 20-May 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic myocarditis & myocardial Degeneration	
Due to Chronic nephritis	
Due to Cerebral hemorrhage	1947
Other conditions (Include pregnancy within 3 months of death) Senility Decubitus ulcers, back, legs & elbows	
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 [signature] (M. D. or other) M.D.
Address Lebanon Mo Date signed 6-2-47

(Licensed Embalmer's Statement on Reverse Side)

Received 6/10/47
Laclede County Health Unit
File No. 6/47-100
Date Filed 6/10/47

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 R. A. Fahiser

Licensed Embalmer No. 1161

P. O. Address Lebanon Mo

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, fact should be so stated above.