

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

40960  
Do not use this space.

1. PLACE OF DEATH

(a) County.....  
(b) Township.....  
(c) City.....  
(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. 701  
Primary Registration District No. 1003  
(d) Street No. ENROUTE CITY HOSPITAL NO. 1 St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)

Registered No. 10652

2. PRINT FULL NAME JAMES R. BARKER

(a) Residence, No. 1538A N. 16TH ST. St. 26  
(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 MALE  
4. COLOR OR RACE WHITE  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) AUG. 31, 1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
47 3 7

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. NIGHT WATCHMAN  
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) ST. LOUIS, MO.

13. NAME WM. J. BARKER

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS, MO.

15. MAIDEN NAME SARAH MC HALE

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

17. INFORMANT (ADDRESS) ELLA JAKO 1538A NO. 16TH ST

18. BURIAL, CREMATION, OR REMOVAL PLACE MEMORIAL PARK DATE DEC. 12, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Goodhart Goodhart 2228 N. Low ave

20. FILED DEC 11 1938 J. D. Brudick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/8/38

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...  
I last saw h... alive on... Death is said to have occurred on the date stated above, at 8:25 P.M.

The principal cause of death and related causes of importance were as follows:

Chronic Broncho Pneumonia  
Abscess of Lung (from tuberculosis)  
Other contributory causes of importance: Chronic Myo Carditis

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

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? Date of injury...  
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?  
If so, specify... (Signed) Joseph M. [Signature] M.D. (Address) [Signature] Coroner

**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.....

*Charles Goodhead*  
.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed *Charles Goodhead*  
.....

Licensed Embalmer No. *2777*  
.....

P. O. Address *2228 Wilson Ave*  
.....

**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.**