

REC'D MAR 15 1939

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

6059
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway 3 Registration District No. 104
(b) Township Fullon 1 Primary Registration District No. 3008
(c) City State Hospital #1 (d) Street No. State Hospital #1 Registered No. 48
(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

Ernest Barrett
(a) Residence, No. St. Louis Mo St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2 2 1902

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
37 37

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. None
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.

FATHER 13. NAME James S. Barrett

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) OK

MOTHER 15. MAIDEN NAME Katharine Barnes

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

17. INFORMANT (ADDRESS) State Hospital #1 - records
Fullon Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE State Hospital Cemetery Feb 10 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Leslie H. H. H. H.
Fullon Missouri

20. FILED Feb. 10, 1939 P. N. Crews
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 8th 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 27th 1939, to Feb 8th 1939
I last saw him alive on Feb 8th 1939. Death is said to have occurred on the date stated above, at 4:25 p.m.
The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance:
Lobar Pneumonia 4/6/39
Facial Emphysema, Mitral Deficiency

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

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No 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. F. Wood M. D.
(Address) State Hospital #1 Fullon Mo.

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.