

APR 3 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **L0502**

Registration District No. **220** Primary Registration District No. **5211** Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Warrick**
(b) City or town **Rural 15 mi.**
(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)

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.? **0** years.

3. (a) PRINT FULL NAME **R. S. Barr**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Elyza Barr** 6. (c) Age of husband or wife if alive **alive years**
7. Birth date of deceased **June 17 1866**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **27** year **1941** hour **12** minute **30** P.M.
21. I hereby certify that I attended the deceased from **Jan 1-11** 19**41**, to **Jan 27** 19**41**;
that I last saw him alive on **Jan 24** 19**41** and that death occurred on the date and hour stated above.

8. AGE: Years **74** Months **6** Days **10** If less than one day, hr. min.
9. Birthplace **Kent** (City, town, or county) **Mo** (State or foreign country)

Immediate cause of death **aneurism of face** Duration **2 yrs.**
Due to _____
Due to **570**

10. Usual occupation _____
11. Industry or business **doctor**
12. Name **William Barr**
13. Birthplace **Keokuk** (City, town, or county) (State or foreign country)
14. Maiden name **Elyzabeth Cox**
15. Birthplace **Mo** (City, town, or county) (State or foreign country)

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.

MOTHER FATHER {
16. (a) Informant **Elyza Barr**
(b) Address **Waburner Mo**
17. (a) **Buried** (b) Date thereof **Jan 29 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Waburner**
18. (a) Signature of funeral director **W. Sparks**
(b) Address **Palmer**
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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? **205**
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **R. B. Parker** (M. D. or other) **D**
Address _____ Date signed **3-3-41**

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

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

Registration District No. 229

Primary Registration District No. 3317

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Boone Twp.
(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
In this community years, months or days (Specify whether)

3. (a) PRINT FULL NAME Russell Sherman Barr
3. (b) If veteran name war
3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife Eliza Barr 6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 17, 1866 (Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 10 If less than one day hr.

9. Birthplace Dent Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation Doctor

11. Industry or business

12. Name Wm Barr

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

14. Maiden name Elizabeth Barr

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

16. (a) Informant Elizabeth Barr

(b) Address Parisville Mo

17. (a) Buried (b) Date thereof 1-28-19 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director Sparks

(b) Address Parisville Mo
19. (a) 12-8-3941 (b) E. E. Galt (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) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27 year 1944 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 Cancer of face 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

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. C. Parker (M. D. or other) Address Parisville Mo Date signed 12-29

S-10502 1941

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.....

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