

FILED MAY 29 1944  
Registration District No. 1947

Primary Registration District No. 6172

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
(a) County Stoddard  
(b) City or town Rural  
(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 about 8 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Stoddard  
(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 Dr. Ray Barnard  
3. (b) If veteran, name war no  
3. (c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 24  
year 1944 hour 11 minute 45 A.M.  
21. I hereby certify that I attended the deceased from April 15  
1944, to April 24 1944  
that I last saw him alive on April 20 1944  
and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race wh  
6. (a) Single, widowed, married, divorced single  
6. (c) Age of husband or wife if alive 1875 years  
7. Birth date of deceased Feb (Month) ? (Day) 1875 (Year)

Immediate cause of death Intestinal Obstruction  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 69 Months 2 Days ?  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Kirksville (City, town, or county) mo (State or foreign country)  
10. Usual occupation Doctor

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name David Barnard  
13. Birthplace Maryland (City, town, or county) (State or foreign country)  
14. Maiden name Mary E. Gray  
15. Birthplace Ohio (City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
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16. (a) Informant Mrs. Kennedy Brooks  
(b) Address House Post Office  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 26-44 (Month) (Day) (Year)  
(c) Place: burial or cremation Galena, mo.  
18. (a) Signature of funeral director W. E. Cheatham  
(b) Address Galena, mo.  
19. (a) 4/25/1944 (Date received local registrar) (b) Deas Allward Deas (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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. E. Cheatham (Date or other) \_\_\_\_\_  
Address Galena, Mo. Date signed 4/25/44

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

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RECEIVED

District Health Officer No. 8,

District File Number 844-650

Date Filed MAY 21 1944

APR 17 1945

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 *Ernest G. Cheatham*

Licensed Embalmer No. 3870

P. O. Address *Halena, 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.