

FILED JUN 14 1945

Registration District No. ....

Primary Registration District No. 1.15 4

Registrar's No. ....

1. PLACE OF DEATH:

(a) County: Stoddard  
(b) City or town: Gray Ridge, Mo. 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 \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME: James Barber

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex: Male 5. Color of race: White 6. (a) Single, widowed, married, divorced: Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: May 24, 1895  
(Month) (Day) (Year)

8. AGE: Years 50 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: Marianso Ark.  
(City, town, or county) (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business: Farming

12. Name: Wm Barber

13. Birthplace: N. Carl  
(City, town, or county) (State or foreign country)

14. Maiden name: Mabel Spencer

15. Birthplace: N. Carl  
(City, town, or county) (State or foreign country)

16. (a) Informant: Walter Barber

(b) Address: Gray Ridge Mo

17. (a) Burial (b) Date thereof: 5 25 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Depts Mo

18. (a) Signature of funeral director: Walter Barber

(b) Address: Depts Mo  
19. (a) May 25 45 (b) Nora Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Stoddard  
(c) City or town: Gray Ridge 103  
(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.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24  
year 1945 hour 7 minute 30 a. M.

21. I hereby certify that I attended the deceased from May 21, 1945, to May 24, 1945, that I last saw him alive on May 21, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: \_\_\_\_\_

Peritonitis

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

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: Dr. W. H. Nix (M. D. or other) \_\_\_\_\_

Address: Eme Mo Date signed: 5/25

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

53  
00  
0

RECEIVED

District Health Office No. 2

District File Number 645-772

Date Filed 6-6-45

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 *Ryman Steele*

Licensed Embalmer No. *2476*

P. O. Address *Hexter M.*

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.