

S. No. 2
DM-5-43
v. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23926

FILED JUN 31 1945

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 537

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(c) Name of hospital or institution: **Springfield Baptist Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Hospital 8 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Carroll 17**
(c) City or town **Route # 4** (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 _____

3. (a) PRINT FULL NAME **Albert Jasper Barner**

3. (b) If veteran, name war **UNK.** 3. (c) Social Security No. **UNK.**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Stella Barner** 6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **Feb. 14 1897**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	53	4	25	hr. min.

9. Birthplace **Carroll Co. Ark.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **George D. Barner**

13. Birthplace **UNK.** **Mo. 0**
(City, town, or county) (State or foreign country)

14. Maiden name **Missouri C. Barner**

15. Birthplace **Macon Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **M. Stella Barner**

(b) Address **Yucca forest Ark.**

17. (a) **Barner** (b) Date thereof **7-9-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hell Camp**

18. (a) Signature of funeral director **Alton Funeral Home**

(b) Address **Berryville, Ark.**

19. (a) **7-6-45** (b) **S. W. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **6**
year **1945** hour **3** minute **35** A. M.

21. I hereby certify that I attended the deceased from **March 1945** to **7/6 1945**
that I last saw him alive on **7/5 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Valvular Heart Disease** Duration **20+ yrs**

Due to **Rheumatic fever**

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy **928**

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 _____
(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 **King Callaway** (M. D. or other) **MD**
Address **Springfield, Mo.** Date signed **7/6/45**

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

988

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 *W E Summerville*
Licensed Embalmer No. *3007*

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, fact should be so stated above.