

U. S. No. 2  
FORM-8-43  
Rev. 5-17-39

29540

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 3653

Registration District No. 149 Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
5805 Holmes Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no.  
In this community 50 years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5805 Holmes 8  
(If rural, give location)  
(e) Citizen of foreign country? no. 0  
(Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Mrs. Louise W. Barrere  
3. (b) If veteran, name war no. 3. (c) Social Security No. no.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August day 31  
year 1945 hour 3:20 minute P. M.  
21. I hereby certify that I attended the deceased from Aug 26  
1945, to Aug 31, 1945  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife George W. Barrere 6. (c) Age of husband or wife if alive dec. years  
7. Birth date of deceased March 11 1858  
(Month) (Day) (Year)

Immediate cause of death Pneumonia, labor fever  
Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
87 5 20 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 108

9. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
at home

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation \_\_\_\_\_  
11. Industry or business X  
12. Name Algeron Winston  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Patton  
15. Birthplace unknown a  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Ada Barrere  
(b) Address 5805 Holmes, Kansas City, Mo.  
17. (a) Burial (b) Date thereof 9-4-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Forest Hill Cemetery

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?  
\_\_\_\_\_

18. (a) Signature of funeral director Stine & McClure  
(b) Address 3235 Gillham Plaza, K. C., Mo.  
19. (a) 9-4-45 (b) Heraldine Holmes  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) MD  
Address 1018 Campbell Date signed 9/1/45

*Angela B. B. B.*

Dr. H. C. Tripp

**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..... *Robert H Reed* .....

Licensed Embalmer No. *3745* .....

P. O. Address..... *N. C. 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.**