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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 11 1947
Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 1002

State File No. 965
Registrar's No. 465

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:
6440 MAIN STREET 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 38 years years, months or days)

3. (a) PRINT FULL NAME MR. JAMES R. BARBER
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MRS. GERTRUDE BARBER 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased OCTOBER 31 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 3 10 hr. min.

9. Birthplace LOUISVILLE - KENTUCKY
(City, town, or county) (State or foreign country)

10. Usual occupation REALTOR

11. Industry or business _____

MOTHER FATHER } 12. Name WILLIAM B. BARBER

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

14. Maiden name LEWIS

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

16. (a) Informant Mrs. Gertrude Barber

(b) Address 6440 Main Street

17. (a) Calvary (b) Date thereof 2-3-47
(Burial, cremation) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director D. H. Newcomes, Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 2-1-47 (b) E. E. Holman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 6440 MAIN STREET
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JANUARY day 31 5ST
year 1947 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from Nov 19 1946 to Jan 31 1947
that I last saw him alive on Jan 21 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Hepatic cirrhosis
Duration 9 mo.

Due to _____

Due to _____

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

Major findings: Of operations 124 B

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 _____

(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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature James H. O'Neil (M. D. or other)

Address 847 Shubert Bldg Date signed 2-1-47

MAR 21 1947

4-1

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 *Melvin Miller*
Licensed Embalmer No. *4407*
P. O. Address *K. 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.