

S. No. 2  
DM-5-43  
v. 5-17-39  
X 36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUL 16 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25111  
Registrar's No. 7014

Registration District No. 297 Primary Registration District No. 6022

1. PLACE OF DEATH:  
(a) County Ray  
(b) City or town Ray  
(c) Name of hospital or institution:  
Smith West Hospital (Ray)  
(d) Length of stay: In hospital or institution 1 (Specify whether  
In this community 69 years (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Ray  
(c) City or town Ray  
(d) Street No. Smith West Hospital (Ray)  
(e) Citizen of foreign country? (Yes or No) No  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Barchers  
3. (b) If veteran, name war none 3. (c) Social Security No. none  
4. Sex male 5. Color or race W  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Barbara Barchers 6. (c) Age of husband or wife if alive 45 years  
7. Birth date of deceased May 24 1859  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 29  
year 1947 hour \_\_\_\_\_ minute 2:20 P.M.  
21. I hereby certify that I attended the deceased from June 18, 1947 to June 29, 1947  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
88 1 5 hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Bronchial Pneumonia Duration 11 days  
Due to Uremic poisoning Hypertrophy of prostate 3 days  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Germany (City, town, or county) (State or foreign country)  
10. Usual occupation Employed  
11. Industry or business Fabrics  
12. Name William Barchers  
13. Birthplace Germany  
14. Maiden name Widow  
15. Birthplace Germany

Major findings:  
Of operations 107  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Henry Barchers  
(b) Address Richmond Mo.  
17. (a) Burial (b) Date thereof 7/2/47  
(c) Place: burial or cremation Crematory, Ray  
18. (a) Signature of funeral director Paul F. H.  
(b) Address Richmond Mo.  
19. (a) July 5, 1947 (b) W. H. Jackson  
(Date received local registrar) (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 2  
23. Signature Dr. E. Q. Reserve Address Richmond, Mo. Date signed July 8, 47

(Licensed Embalmer's Statement on Reverse Side)

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

89  
0  
0

RECEIVED

District Health Officer No. 8,

District File Number

9-15-47

Date Filed

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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

*George White*

Licensed Embalmer No. 4066

P. O. Address

*Richmond, Va.*

**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.**