

V. S. No. 2
FORM-5-43
Rev. 5-17-39
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40460

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

State File No. _____

FILED DEC 8 1947
Registration District No. 367

Primary Registration District No. 6876

Registrar's No. 2476

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Overland, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
10506 Maddox Place
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) _____ (Specify whether)

In this community 10 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Overland 13
(If outside city or town limits, write "RURAL")

(d) Street No. 10506 Maddox Place !
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Thomas A. Barr

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

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Anna L. Barr 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 30, 1855
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	92	6	0	hr. min.

9. Birthplace Marion Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Pancher (retired)

11. Industry or business _____

12. Name John M. Barr

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

14. Maiden name Mary Johnson

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

16. (a) Informant Flossie Windsor

(b) Address 10506 Maddox Place, Overland, Mo.

17. (a) Cremation (b) Date thereof Dec. 1, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Ortmann Funeral Home

(b) Address 9222 Lackland Ave. Overland, Mo.

19. (a) 12-1-47 (b) Beul G. Stapp
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 30 year 1947 hour _____ minute 4:30 A. M.

21. I hereby certify that I attended the deceased from Oct 4 to Nov 30, 1947, that I last saw him alive on Nov 30, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Chol. Myocarditis Duration 7 wks.

Due to arteriosclerosis (by pathology of prostate) 2 nos.

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93D

Major findings:
Of operations _____
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? _____

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

23. Signature Thomas A. Barr (M. D. or other) M.D.
Address 844 E. Cleveland Date signed 12/1/47

(Licensed Embalmer's Statement on Reverse Side)

St Louis 14, Mo

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..... *Al O. Ostmann*
Licensed Embalmer No. *3478*
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.