

FILED SEP 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30230

BIRTH NO.		REG. DIST. NO. 141		PRIMARY REG. DIST. NO. 3025		Registrar's No. 38	
1. PLACE OF DEATH a. COUNTY Howell				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN West Plains		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Willow Springs,		1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rest Home				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) Taylor		a. (First) Taylor		b. (Middle) W.		c. (Last) BARR	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W		8. DATE OF BIRTH Aug. 14, 1866	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kearney, Mo.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Bowman Barr, U.S. Army ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 4 1/2 22	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 17, 1950 , to July 2, 1950 , that I last saw the deceased alive on July 2, 1950 , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) Dr. Richard A. Smith, D.O.		23b. ADDRESS 913 W. Main, West Plains, Mo.		23c. DATE SIGNED 7-22-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY Nease Cemetery		24d. LOCATION (City, town, or county) (State) Willow Springs, Mo.	
DATE REC'D BY LOCAL REG. 9-6-50		REGISTRAR'S SIGNATURE Beatrice Cook		FUNERAL DIRECTOR'S SIGNATURE Robertson		ADDRESS West Plains, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED SEP 11 1950

Dist. File 950-1895

Date Filed 9-19-50

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.