MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

31088

1. PLACE OF DEATH

County: Marion — Registration District No.: 547 — File No.:

Township: ~~Mason~~ — Primary Registration District No.: 3029 — Registered No.: 245

City: Hannibal (No. Levering Hospital St. Ward)

2. FULL NAME Charles Vern Barr

(a) Residence. No. 923 South Arch St St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Susan Barr

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 2, 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	1	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work R.R. Employe-Wabash
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Ohio

PARENTS

10. NAME OF FATHER Lewis Barr

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Pa.

12. MAIDEN NAME OF MOTHER Murcer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown

14. INFORMANT Freda Williams
(Address) Hannibal

15. FILED 9/12, 1928 C. E. Steele MM REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept, 10 28

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1928, to Sept 10, 1928 that I last saw him alive on Sept 10, 1928 and that death occurred, on the date stated above, at 1:45 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Obstruction of Intestines

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? —
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. A. Chittam M. D
, 19 (Address) Hannibal Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Olive ~~Riverside Cemetary~~ — DATE OF BURIAL 9/15 1928

20. UNDERTAKER Wm M. Smith — ADDRESS Hannibal

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Marion — Registration District No. 547 — File No.

Township Mason — Primary Registration District No. 3029 — Registered No. 245

City Hannibal (No. ..... St. ..... Ward)

2. FULL NAME Charles Vern Barr

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 10 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Obstruction of Intestines

(duration) ..... yrs. ..... mos. ..... ds.

IBUTORY
ONDARY)

(duration) ..... yrs. ..... mos. ..... ds.

ERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

D AN OPERATION PRECEDE DEATH? ..... DATE OF

AS THERE AN AUTOPSY?

HAT TEST CONFIRMED DIAGNOSIS?

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or MICIDAL.

I do not know
did not make
Past month

Take This To
ST. MARY'S PHARMACY
2907 St. Marys Ave.
Phone 432
Call For and Deliver

U.S.

14. INFORMANT .....
(Address)

15. FILED 9/12, 1928 C E Strode REGISTRAR

PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

N. B.—Every ... should be stated EXACTLY. PHYSICIANS should ... ed. Exact statement of OCCUPATION is very important. ... UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

CAUSE OF D... REGISTRAR

S-31088