53
APR 25 1929

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

Do not use this space.

11317

File No. ....

Registered No. 1682

1. PLACE OF DEATH
County LACLEDE
Registration District No. 449
Township WASHINGTON
Primary Registration District No. 5612
City .... (No. .... St. .... Ward)

2. FULL NAME HARROLD E. BARBER

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) APR. 25 – 1925

7. AGE: Years 3 | Months 10 | Days 21 | If LESS than 1 day, ... hrs. or .... min.

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

9. BIRTHPLACE (CITY OR TOWN) SPRINGFIELD
(STATE OR COUNTRY) MO

PARENTS

10. NAME OF FATHER H. E. BARBER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ....
(STATE OR COUNTRY) KANSAS
12. MAIDEN NAME OF MOTHER ALMA OLIVER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ....
(STATE OR COUNTRY) MO

14. INFORMANT H. E. Barber
(Address) LEBANON MO

15. FILED 3/18 1929 J. M. Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) MAR 16 1929

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ examined the deceased Mar 16th 1929, 19.... that I last saw h.... alive on 3/1 this date, 19...., and that death occurred, on the date stated above, at 9 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary tuberculosis
23A
(duration) few months yrs. .... mos. .... ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ....
DID AN OPERATION PRECEDE DEATH? .... DATE OF ....
WAS THERE AN AUTOPSY? ....
WHAT TEST CONFIRMED DIAGNOSIS? ....
(Signed) J. B. Herbert, M. D.
3-18, 1929 (Address) Lebanon 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: WASHINGTON CHURCH
DATE OF BURIAL: 3 – 17 1929

20. UNDERTAKER: PALMER
ADDRESS: LEBANON

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD