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

Do not use this space.

18805

JUN 27 1929

1. PLACE OF DEATH
County Miller Registration District No. 561
Township Saline Primary Registration District No. 4330
City ..... (No. ..... St. ..... Ward)

File No. .....
Registered No. 32

2. FULL NAME Berry C Barbour

(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)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 3. 1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	62	7	9	

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

9. BIRTHPLACE (CITY OR TOWN) Miller Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER C.C. Barbour
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentuckey
12. MAIDEN NAME OF MOTHER Alberta Taylor
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Miller Co.
(STATE OR COUNTRY) Mo

14. INFORMANT John Barbour
(Address) Eldon

15. FILED 5-18. 1929 Belle Haynes.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12 19

17. I HEREBY CERTIFY, That I attended deceased from 9/1, 1928 to 5/12, 1929, that I last saw h..... alive on 5/12, 1929, and that death occurred, on the date stated above, at 12:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Spasms of muscles of throat
11 09
Don't know (duration) ..... yrs. ..... mos. 9 ds.
CONTRIBUTORY (SECONDARY) Chronic Nephritis
Don't know (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? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Signs
(Signed) G.D. Wallen, M. D
, 19 (Address) Eldon 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	DATE OF BURIAL
Freedom Cem. Morgan Co Mo.	5-13 1929
20. UNDERTAKER	**ADDRESS**
U R Phillips	Eldon

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.

Dr. G. D. Walker,
Eldon, Mo.