

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

Do not use this space.

38671

1. PLACE OF DEATH

County
Township
City *St. Louis mo.*

Registration District No. *791*
Primary Registration District No. *10118*

File No.
Registered No. *11084*
St. Ward)

2. FULL NAME

(a) Residence. No. *John Barker*
(Usual place of abode) *1836 Duane St.*

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *6* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *col.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) *Divorced*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *10-20-1880*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 - 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Miss.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Jesse Barker*

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

12. MAIDEN NAME OF MOTHER *Nessie Jones*

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

14. INFORMANT *A. Gertrude Creath*
(Address) *City Hospital #2*

15. FILED *OV 13 1929* *W. C. Starck*
19. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11/6/29* 19

17. I HEREBY CERTIFY, That I attended deceased from *11-5-29*, 19....., to *11-6-29*, 19..... that I last saw him alive on *11-6-29* and that death occurred, on the date stated above, at *5:30* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: *5:30 AM*

Lobar Pneumonia (Left)
101 (duration) 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? *no* DATE OF

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Autopsy*
(Signed) *A. E. ...* M. D.

11/6/29 (Address) *City Hospital #2*
*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

father Dickson *11-14 19 29*
4. UNDERTAKER *A. F. Walker*
ADDRESS *2701 Stoddard*

K. E.—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.

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