

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

Do not use this space.

4815

1. PLACE OF DEATH

County Laverne
Towship Silva
City Silva Springs, Mo.

Registration District No. 1110
Primary Registration District No. 35-461

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Wm J. Barker

(a) Residence, No. _____ St. _____ Ward _____
(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 ma 4. COLOR OR RACE wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 22-1881

7. AGE YEARS 49- MONTHS _____ DAYS 27 If LESS than 1 day, _____ hrs. or _____ min.

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

9. BIRTHPLACE (CITY OR TOWN) Levensburg, Ky.
(STATE OR COUNTRY)

10. NAME OF FATHER Chas Barker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

12. MAIDEN NAME OF MOTHER Margaret Beecher

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Mrs. Lillie Barker
(Address) Silva Springs, Mo.

15. FILED 2/20 19 30
G M Cearley REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) 2/18 19 30

17. I HEREBY CERTIFY, That I attended deceased from 2-18-1930 to 2-18-1930
that I last saw him alive on 2-18-1930 and that death occurred, on the date stated above, at 6:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterial Fibrillation
Chronic myocarditis
Chronic cardiac valvular disease
mitral regurgitation (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 92A
93C
95A

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. Claude Bohm, M. D.

2-21-1930 (Address) West Plains, 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

Silva Springs 2/20 19 30

20. UNDERTAKER ADDRESS None

