

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

Do not use this space.

APR 30 1930

File No. **11327**
Registered No. **17**
St. _____ Ward _____

1. PLACE OF DEATH

County Scott
Township _____
City Chaffee (No. _____)

Registration District No. 816
Primary Registration District No. 4492

2. FULL NAME

James Edgar Barber
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 6, 30

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	—	—	18	

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) Chaffee Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Edgar Barber

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

12. MAIDEN NAME OF MOTHER Pauline O'Connor

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

14. INFORMANT Edgar Barber
(Address) Chaffee Mo.

15. FILED 3-25-30 W. Sample REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/25 1930

17. I HEREBY CERTIFY, That I attended deceased from 3/6 1930, to 3/25 1930, that I last saw him alive on 3/20 1930, and that death occurred, on the date stated above, at 7:30 am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth 7th month
Malassimilation
15.9
15.8
(duration) yrs. mos. 18 ds.

CONTRIBUTORY (SECONDARY) 16/2
(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? W. Sample M. D.
(Signed) _____

3/25 1930 (Address) Chaffee 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 Union Park Cem Chaffee Mo DATE OF BURIAL 3/25 1930

20. UNDERTAKER Dispenhough & Hubbard ADDRESS Chaffee Mo

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.

