

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

Do not use this space.

12268

1. PLACE OF DEATH

County Lentz
Township Albany
City Albany (No.)

Registration District No. 309
Primary Registration District No. 4185

File No.
Registered No. 20
St. Ward)

2. FULL NAME

Mamma Bella Barker
(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 Life 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 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) March 11, 1907

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
23 1 5

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) allendale
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Wm Barker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) allendale
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Ethie Marshall
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Lentz
(STATE OR COUNTRY) Mo.

14. INFORMANT Wm Barker
(Address) allendale

15. FILED Apr 21, 1930 W. T. Martin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-16-1930

17. I HEREBY CERTIFY, That I attended deceased from 9-16-1929 to 4-16-1930
that I last saw h. alive on 4-16-1930, and that death occurred, on the date stated above, at 10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Fat Embolism

(Patient weighed 260 lbs)

127B (duration) yrs. mos. 2 ds.
117B CONTRIBUTORY Operation Appendicitis
(SECONDARY)

67B (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1. DID AN OPERATION PRECEDE DEATH. yes DATE OF 4-10-30

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) Frank H. Rose, M. D.

4-17-1930 (Address) Albany, 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 Kirk Cemetery DATE OF BURIAL 4-17 1930

20. UNDERTAKER Arch C. Duffee ADDRESS Leant city

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.

29 1930

