

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

Do not use this space.

16398

1. PLACE OF DEATH U.S.V.Hosp.

County Jackson
Township Kaw
City Kansas City, Mo. (No. U.S.V. Veterans Hosp.)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 2507
St. _____ Ward _____

2. FULL NAME BARB, Francis Clyde

C-1 039 993 WOE

(a) Residence. No. 428 Ohio St. St., _____ Ward. Chief, Machinist Mate
(Usual place of abode) Topeka, Kansas. (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 **Male**
4. COLOR OR RACE **White**
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mrs. Dorothy Barb**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec. 6, 1897**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	32	5	25	

8. OCCUPATION OF DECEASED **Aviator**
(a) Trade, profession, or particular kind of work 21407 81A
(b) General nature of industry, business, or establishment in which employed (or employer) 134A
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Athens, Tenn.**
(STATE OR COUNTRY)

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Hospital Records.**
(Address) Kansas City Mo

15. FILED 62 19 30 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 31 1930**

17. I HEREBY CERTIFY, That I attended deceased from **March 24**, 19**30**, to **May 31**, 19**30**, that I last saw h. **im** alive on **May 31**, 19**30** and that death occurred, on the date stated above, at **11:25 P.M.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fracture 1st Lumbar vertebra (Accidental Aeroplane accident in Service) with Myelitis
(duration) **9** yrs. mos. ds.

CONTRIBUTORY (1) **Renal Calculi Left.** (SECONDARY)
(2) **Acute Mastoiditis, left.**
(duration) **Unknown** mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. _____
3-26-30

DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **5-27-30**
1 Mastoid Radical Operation
1 Nephrectomy

WHAT TEST CONFIRMED DIAGNOSIS
Microanalysis
(Signed) _____, M. D.
W.E. CHAMBERS, Medical Officer in Charge U.S.V. Hospital, Kansas City, Missouri.

*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 **Topeka Kansas**
DATE OF BURIAL **6/3 1930**

20. UNDERTAKER **Melody McVilly Funeral Home**
ADDRESS **3133 Euclid**

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.

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