

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

Do not use this space.

3178

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis Mo.** (No. **Sanitarium**) St. Ward)

File No.
Registered No. **393**
St. Ward)

2. FULL NAME

Wheeler Barber
(a) Residence No. **1419 So. 12th** St., **13** Ward.
(Usual place of abode)
Length of residence in city or town where death occurred **1** yrs. **8** mos. - da. How long in U.S., if of foreign birth? yrs. mos. da.
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE white	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 2, 1850		
7. AGE	YEARS	MONTHS
	80	5
		DAYS
		27
		IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... **Farmer (formerly)**
(b) General nature of industry, business, or establishment in which employed (or employer)..... **Unknown**
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... **Marion County**
(STATE OR COUNTRY)..... **Ohio**

10. NAME OF FATHER..... **Unknown**
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... **Washington**
(STATE OR COUNTRY)..... **D.C.**
12. MAIDEN NAME OF MOTHER..... **Unknown**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... **Ohio**
(STATE OR COUNTRY).....

14. INFORMANT..... **John G. Ryan M.D.**
(Address) **5700 Arsenal St**

15. FILED..... **11** 19**31** **May C. Kahl** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **1-9 1931**
17. I HEREBY CERTIFY, That I attended deceased from **11-17 1930**, to **1-9 1931**, that I last saw him alive on **1-9 1931**, and that death occurred, on the date stated above, at **5:45 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia (lobar)
108 (duration) yrs. mos. **9** ds.
930 **Ch. Myocarditis**
(SECONDARY) (duration) yrs. mos. **3** ds.

18. WHERE WAS DISEASE CONTRACTED.....
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
(Signed) **John G. Ryan** M. D.
1-9 1931 (Address) **5700 Arsenal St**

*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..... **Deniset Park**
DATE OF BURIAL..... **Jan 12 1931**

20. UNDERTAKER..... **Wreck Proor**
ADDRESS..... **2201 So Grand**

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.

