

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

Do not use this space.

14729

1. PLACE OF DEATH

54 County Hajayete
Township Dover
City Louisiana Home (No. _____)

Registration District No. 460
Primary Registration District No. 5623-B

File No. _____
Registered No. 28
St. _____ Ward _____

2. FULL NAME

William M. Barby

(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. (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) Dec 8 1877

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	93	4	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. 93C 16a
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Jaromine
(STATE OR COUNTRY) Kentucky

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ken
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT (Address) H.P. Hader

15. FILED 4-9-31 Essie P. Porter
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 8 1931

17. I HEREBY CERTIFY, That I attended deceased from Apr 7, 1931, to Apr 8, 1931
that I last saw him alive on Apr 8, 1931, and that death occurred, on the date stated above, at 9:05 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocardial disease
(duration) ? yrs. mos. ds.

CONTRIBUTORY Dementia (duration) ? yrs. mos. ds.
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED 93C

IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) J. Davison Geyer M. D.

. 19 Higginsville Mo

*State the DISEASE CAUSING DEATH, or to 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 Confederate Home Cemetery DATE OF BURIAL 4/9/31

20. UNDERTAKER H. Hader, Higginsville, Mo ADDRESS _____

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. APR 23 1931

