

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.

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

REC'D JAN 13 1939

43748  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Marion 2 Registration District No. 546  
 (b) Township Johnson 1 Primary Registration District No. 5735 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lena M. Barr

(a) Residence, No. \_\_\_\_\_ St. ☐ (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Albert Barr

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-15-1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
74 - 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) Sep 15-38 11. Total time (years) spent in this occupation 40 7 2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alledo Ill 1

13. NAME John Stevens

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn 1

15. MAIDEN NAME Janet Knauch 9

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Janet Knauch

17. INFORMANT (ADDRESS) Mrs. Lee Quaker  
Richards Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Broadway City DATE 12-19 1938

19. FUNERAL DIRECTOR (ADDRESS) W. E. Kuchler  
St. James Mo

20. FILED Dec 21 1938 Sam A. Warner Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-18 1938

22. I HEREBY CERTIFY That I attended deceased from Dec 9 1938 to Dec 11 1938

I last saw her alive on Dec 17 1938 Death is said

to have occurred on the date stated above, at 10:45 a.m.

The principal cause of death and related causes of importance were as follows:

Pneumonia ✓ Date of onset \_\_\_\_\_

Other contributory causes of importance:

Hypertension

Name of operation None Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) O. J. Jones M.D.

(Address) Richards Mo

**STATEMENT BY LICENSED EMBALMER**

I, W E Ricklider, Licensed Embalmer No. 1970

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me,

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed W E Ricklider

Licensed Embalmer No. 1970

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

43748  
Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 546  
(b) Township Johnson Primary Registration District No. 5735  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lena M. Barr

(a) Residence, No. \_\_\_\_\_ St. ☐ (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

|                                                              |                                                                                    |                                                                       |
|--------------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| 3. SEX<br><u>7</u>                                           | 4. COLOR OR RACE<br><u>W</u>                                                       | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)<br><u>M</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF |                                                                                    |                                                                       |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)                      |                                                                                    |                                                                       |
| 7. AGE                                                       | YEARS<br><u>74</u>                                                                 | MONTHS<br><u>-</u>                                                    |
|                                                              | DAYS<br><u>29</u>                                                                  | If LESS than 1 day, _____ hrs. or _____ min.                          |
| OCCUPATION                                                   | 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. |                                                                       |
|                                                              | 9. Industry or business in which work was done, as saw mill, bank, etc.            |                                                                       |
|                                                              | 10. Date deceased last worked at this occupation (month and year)                  |                                                                       |
|                                                              | 11. Total time (years) spent in this occupation                                    |                                                                       |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)             |                                                                                    |                                                                       |
| FATHER                                                       | 13. NAME                                                                           |                                                                       |
|                                                              | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)                                   |                                                                       |
| MOTHER                                                       | 15. MAIDEN NAME                                                                    |                                                                       |
|                                                              | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)                                   |                                                                       |
| 17. INFORMANT (ADDRESS)                                      |                                                                                    |                                                                       |
| 18. BURIAL, CREMATION, OR REMOVAL                            |                                                                                    |                                                                       |
| PLACE _____ DATE _____, 19____                               |                                                                                    |                                                                       |
| 19. FUNERAL DIRECTOR (ADDRESS)                               |                                                                                    |                                                                       |
| 20. FILED _____, 19____                                      |                                                                                    |                                                                       |

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-18, 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Pneumonia Lobor  
108

Other contributory causes of importance:  
Hypertension

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) O. H. Jones, M. D.  
(Address) Chicago, Mo

