DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11472

Registration District No. 449 Primary Registration District No. 4267 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 320 N. Madison (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether In this community 40 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclede
(c) City or town Lebanon (If outside city or town limits, write "RURAL")
(d) Street No. 320 N. Madison (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Frances Marion Barr 100

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Josie Drewin

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct (Month) 19 (Day) 1857 (Year)

8. AGE: Years 82 Months 11 Days 21 If less than one day hr. min.

9. Birthplace (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business

FATHER
12. Name Matt Barr
13. Birthplace (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Rebecca Farmer
15. Birthplace (City, town, or county) NOT KNOWN (State or foreign country)

16. (a) Informant's own signature Mrs Gerald Fleming
(b) Address 320 N Madison Lebanon Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (Month) 13 (Day) 1940 (Year)
(c) Place: burial or cremation WHITE OAK CEM

18. (a) Signature of funeral director Palmers
(b) Address Lebanon Mo

19. (a) 3-11-40 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 11 year 1940 hour 8 minute 10 M.

21. I hereby certify that I attended the deceased from Feb 20 — 1940, to March 11 — 1940, that I last saw him alive on March 3 — 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration 4 Days
Due to Paralysis — Duration 9 Days
Due to Arteriosclerosis — Duration 6 weeks
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations
Of autopsy
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature T. H. Casey (M. D. or other)
Address Lebanon Mo. Date signed 3-11-1940

(Licensed Embalmer's Statement on Reverse Side)

Rev. 6-17-39
16-1 X19511

RECEIVED
District Health Officer No. 7.
District File Number 4-40-643
Date Filed 4-12-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or ~~by~~:.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed D M Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon Mo

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.)

If this body is not embalmed, above space should be left blank.