

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18967**

FIL JUN 12 1940

Registration District No. **546**

Primary Registration District No. **5735**

Registrar's No. **7**

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

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Wichita** Rural
(c) Name of hospital or institution:

(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 **2**
years, months or days)

3. (a) PRINT FULL NAME **Albert B. Barr**

8. (b) If veteran, name war **_____** 3. (c) Social Security No. **_____**

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife **_____** 6. (c) Age of husband or wife if alive **_____** years

7. Birth date of deceased **2** **4** **1861**
(Month) (Day) (Year)

8. AGE: Years **79** Months **2** Days **23** If less than one day **_____** hr. **_____** min.

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

10. Usual occupation **Farmer**

11. Industry or business **_____**

12. Name **Samuel Barr**

13. Birthplace **South Korea**
(City, town, or county) (State or foreign country)

14. Maiden name **South Korea**

15. Birthplace **_____**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ida Lester**

(b) Address **Wichita Mo**

17. (a) **Burial** (b) Date thereof **4 29-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Broad way**

18. (a) Signature of funeral director **W. E. Licklider**

(b) Address **St James Mo**

19. (a) **April 28-1940** (b) **Sam A. Warner**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Marion**

(c) City or town **Wichita** Rural
(If outside city or town limits, write "RURAL")

(d) Street No. **2 mi north of Wichita**
(If rural, give location)

(e) If foreign born, how long in U. S. A? **_____** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **27**
year **1940** hour **4 P** minute **_____** M.

21. I hereby certify that I attended the deceased from **April 1**, 1940, to **April 27**, 1940;
that I last saw him alive on **April 27**, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death **Reported as chronic Abscess formation**

Due to **Reported as chronic Abscess formation**

Due to **_____**

Other conditions **None** **127**
(Include pregnancy within 3 months of death)

Major findings: Of operations **✓**

Of autopsy **no**

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? **485**

(Specify type of place) While at work **_____** (e) Means of injury **_____**

23. Signature **W. E. Licklider** (M. D. or other) **1**

Address **Wichita** Date signed **6/3/40**

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

W E Richlender

Licensed Embalmer No.

1920

P. O. Address

St James 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.