

Registration District No. 86-2-3-1940 Primary Registration District No. 6135- Registrar's No. 40

1. PLACE OF DEATH:

(a) County Texas  
(b) City or town Bovina  
(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 20 (Specify whether)  
In this community 11 years  
years, months or days

3. (a) PRINT FULL NAME MILTON SAUL BARR  
(b) If veteran, name war  
(c) Social Security No. 24464961

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced M  
(b) Name of husband or wife Mary Elizabeth Barr  
(c) Age of husband or wife if alive 31 years  
7. Birth date of deceased March 31 1867  
(Month) (Day) (Year)

8. AGE: Years 73 Months 5 Days 17 If less than one day hr. min.

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

10. Usual occupation Farmer

11. INDUSTRY OR BUSINESS  
12. Name Saul Barr  
13. Birthplace Tex. (City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Howard Barr  
(b) Address Cabot R. # 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19 40 (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Pleasant

18. (a) Signature of funeral director W. J. Elliott  
(b) Address Cabot R. # 2

19. (a) Sept 18 (Date received local registrar) (b) Mrs. Clara Cunningham (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas  
(c) City or town Rural  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 hour 6:30 minute A.M.  
Year 1940

21. I hereby certify that I attended the deceased from Jan. 13 1940 to Sept 10 1940  
that I last saw her alive on Sept 16 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cholera  
867  
Due to Barditis

Due to  
Other conditions (Include pregnancy within 3 months of death) 95%

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?  
While at work? (Specify type of place) (e) Means of injury  
Major findings:  
Of operations  
Of autopsy

23. Signature J. W. McComb (M. D. or other)  
Address Cabot R. # 2 Date signed 9-17-40  
789

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 1040977

Date Filed \_\_\_\_\_

**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 Frederick Vell...

Licensed Embalmer No. 5252

P. O. Address Carol...

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **333 45-7**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **862**

Primary Registration District No. **613J**

Registrar's No. ....

1. PLACE OF DEATH:

(a) County **Texas**  
(b) City or town **Burden, T.S.**  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL.")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Milton Saul Barr**

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 **m**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased **Mar 31 1897**  
(Month) (Day) (Year)

8. AGE: Years **73** Months **5** Days **17** If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **Oct 1, 40** (b) **Mrs. Choris Cunningham**  
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: month **Sept** day **17**  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature **M. C. Coyle** (M. D. or other) \_\_\_\_\_

Address **Carroll Mo** Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

