DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2919

Registration District No. 407 Primary Registration District No. 4241 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carterville (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 220 North Pine (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 10 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Carterville (If outside city or town limits, write "RURAL") 4

(d) Street No. 220 N. Pine (If rural, give location) 0

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME JAMES H. BARKER

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race W.

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Mary Baker

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
78	4	11	hr. min.

9. Birthplace No data (City, town, or county) Ky. 1 (State or foreign country)

10. Usual occupation Grocery man

11. Industry or business Grocery store

FATHER
12. Name W. L. Barker
13. Birthplace No data (City, town, or county) Ky 1 (State or foreign country)

MOTHER
14. Maiden name E. Shackelford
15. Birthplace No data (City, town, or county) Ky 1 (State or foreign country)

16. (a) Informant Mary Barker

(b) Address Carterville

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2 10 41 (Month) (Day) (Year)

(c) Place: burial or cremation Mulberry Kans

18. (a) Signature of funeral director Hedge Nelson

(b) Address Webb City Mo.

19. (a) Feb. 10 1941 (Date received local registrar) (b) J. W. Clark (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 7 year 1941 hour 4:45 minute P. M.

21. I hereby certify that I attended the deceased from January 20, 1941, to Feb 7, 1941; that I last saw him alive on Jan 28, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the Tongue

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

45 b

PHYSICIAN

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 G. W. Cox (M. D. or other) D.O.

Address Webb City, Mo Date signed 2-10-41

(Licensed Embalmer's Statement on Reverse Side)

Cor

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 T. W. Hedge, Registered Apprentice No. ..... working under my personal supervision.

Signed T. W. Hedge

Licensed Embalmer No. 2859

P. O. Address Webb City 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, fact should be so stated above.

o. 2B
1 1:40
2659

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

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2919

Registration District No. 407 Primary Registration District No. 4241 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carterville (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 James H Barker

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 Sept. (Month) 26 (Day) — 1862 (Year)

8. AGE:

Years	Months	Days	If less than one day
78	4	11	hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Feb. 10-1941 (Date received local registrar) (b) J. W. Clark (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 7 year 1941 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

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 G. W. Cox (M. D. or other)

Address Webb City Mo Date signed

WHITE PLAINLY—USE UNFADING BLACK INK—WHITE A PERMANENT RECORD

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

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

1. PLACE OF DEATH:

(a) County .....

(b) City or town ..... (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 years, months or days)

In this community .....

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 .....

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

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

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

7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

REHEAT FAMILY

12. Name .....

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

REHEAT MOTHER

14. Maiden name .....

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

16. (a) Informant .....

(b) Address .....

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

(c) Place: burial or cremation .....

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

(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... hour ..... minute ..... M.

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

Immediate cause of death ..... Duration .....

Due to .....

Due to .....

Other conditions ..... (Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN

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 ..... (M. D. or other) .....

Address ..... Date signed .....