

Registration District No. 677Primary Registration District No. 4403Registrar's No. 33

1. PLACE OF DEATH

(a) County Polk
 (b) City or town Rolla, Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Trachoma Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 days
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Gas. Fredrick Barrett3. (b) If veteran, name war 3. (c) Social Security No. 4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m6. (b) Name of husband or wife Grace E. Barrett 6. (c) Age of husband or wife if alive 45 years7. Birth date of deceased Oct 12-1887
(Month) (Day) (Year)8. AGE: Years 53 Months 2 Days 19 If less than one day hr. min.9. Birthplace Bristol Va. (City, town, or county) (State or foreign country)10. Usual occupation Carpenter & Farmer

11. Industry or business

12. Name David Barrett13. Birthplace Va. (City, town, or county) (State or foreign country)14. Maiden name Gene Lewis15. Birthplace Va. (City, town, or county) (State or foreign country)16. (a) Informant Mrs. Grace Barrett(b) Address West View, Mo17. (a) R - (b) Date thereof 1-31-41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Howell Valley18. (a) Signature of funeral director Mrs. Harry McCaw(b) Address Rolla, Mo.19. (a) Jan. 31, 1941 (b) Jos. F. Ayers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Polk
 (c) City or town Rolla
 (If outside city or town limits, write "RURAL")
 (d) Street No. Trachoma Hosp
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31
year 1941 hour minute M.21. I hereby certify that I attended the deceased from 1-30, 1941, to 1-31, 1941;that I last saw him alive on January 31, 1941;
and that death occurred on the date and hour stated above;Immediate cause of death: Cardiac Failure DurationDue to Not Known

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?

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

23. Signature Leont. Weisich (M. D. or other) D
Address Trachoma Hosp. Rolla Mo Date signed 1-31-41

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

200a

RECEIVED

District Health Officer No. 5,

District File Number 24/24

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 _____

~~working under my personal supervision.~~

Registered Apprentice No. _____

Signed

R. E. McQuinn

Licensed Embalmer No.

3953

P. O. Address

Rolla

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3818

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Sheppards
(b) City or town Rolla
(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 Jos. Frederick Barrett

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 _____ (Month) (Day) (Year)

8. AGE: Years 53 Months 2 Days 19 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 31 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.

Immediate cause of death Cardiac failure Chronic myocarditis
Due to Heart unknown

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 93A

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? _____

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

23. Signature Leon T. Weppich md (M. D. or other) _____ Address Rolla, Mo Date signed _____

SUPPLEMENTARY

