

Registration District No. **216**

Primary Registration District No. **5378**

1. PLACE OF DEATH:

(a) County **Dent**
(b) City or town **Rural - Watkins**
(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 **60 years** (Specify whether years, months or days)
In this community

3. (a) PRINT FULL NAME **Robert Franklin Barrow**

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

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

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive **4** years

7. Birth date of deceased **9** (Month) **4** (Day) **1859** (Year)

8. AGE: Years **81** Months **4** Days **29** If less than one day hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business

12. Name **John Barrow**

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

14. Maiden name **Caroline Easterwood**

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

16. (a) Informant **Thomas Jackson Barrow**

(b) Address **Auburn Hill**

17. (a) **Burial** (b) Date thereof **2 5-1941** (Month) (Day) (Year)

(c) Place: burial or cremation **Rural Road**

18. (a) Signature of funeral director **Robert Chaulhan**

(b) Address **Salem, Mo.**

19. (a) **2-4-41** (Date received local registrar) (b) **F. E. Smith, Md.** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Dent** 33
(c) City or town **Rural - Watkins** 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **3**
year **1941** hour **8-10 P** minute **✓** M.

21. I hereby certify that I attended the deceased from **Jan 28**
1941 to **Feb 3** 1941
that I last saw him alive on **Feb 2** 1941
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia Lobes**
P & L

Due to **Asphyxia** 78
Due to **Asphyxia** 78

Other conditions (Include pregnancy within 3 months of death) **✓**

Major findings: Of operations **✓**
Of autopsy **AD**

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?

23. Signature **A. G. Lillian** (M. D. or other) **✓**
Address **Salem Mo** Date signed **2-4-41**

RECEIVED
District Health Officer No 5,
District File Number 371390
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.....

N. D. Holman, Registered Apprentice No.....
working under my personal supervision.

Signed N. D. Holman

Licensed Embalmer No. 928

P. O. Address Salem 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.