No. 2
4-13-40
4-17-39

FILED JUL 10 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21181

Registration District No. 85 | Primary Registration District No. 1001 | Registrar's No. 339

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

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Mehtodist Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 7 weeks (Specify whether years, months or days)
In this community: life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Gentry
(c) City or town: Albany (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: Allan T. Bare
3. (b) If veteran, name war: —
3. (c) Social Security No. NONE
4. Sex: male
5. Color or race: white
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Pearl Bare
6. (c) Age of husband or wife if alive: 45 years
7. Birth date of deceased: October (Month) 15 (Day) 1884 (Year)
8. AGE: Years 56 | Months 8 | Days 6 | If less than one day: hr. min.
9. Birthplace: Albany (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Mortician
11. Industry or business: Bare Funeral Home
FATHER
12. Name: Henry W. Bare
13. Birthplace: Unknown (City, town, or county) Kentucky (State or foreign country)
MOTHER
14. Maiden name: Julia Ann Rounder
15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant: Mrs. A. T. Bare
(b) Address: Albany, Mo.
17. (a) ~~burial~~ (Burial, cremation, or removal) (b) Date thereof: June 23, 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Albany, Mo.
18. (a) Signature of funeral director: Yeaton-Beyle & Bauman
(b) Address: St. Joseph, Mo.
19. (a) 6/21/41 (Date received local registrar) (b) H. J. Meltebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: June day: 21 year: 1941 hour: 7 minute: 10 A. M.
21. I hereby certify that I attended the deceased from May 2, 1941, to June 21, 1941, that I last saw him alive on June 21, 1941, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis @ Cystitis & Cort Lobar	6 days
Due to: (Sub-diaphragmatic abscess)	6 weeks
Due to: Pleurisy with effusion	10 days
Other conditions: (Include pregnancy within 3 months of death)	

Major findings:
Of operations: Abscess above liver
Of autopsy: No

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: H. S. Sourwood (M. D. or other) M.D.
Address: St. Joseph, Mo. Date signed: 6-21-41

(Licensed Embalmer's Statement on Reverse Side)

127 B

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 6/21/41

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Wm E Summerfield

Licensed Embalmer No. 3007

P.O. Address 919 S 10 St Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
—4-25-41
X27852

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21181

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 639

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(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) Citizen of foreign country (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Allan T. Bare

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	Months	Days	If less than one day
56	8	6	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) 8-26-41 (Date received local registrar) (b) H. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21
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 Myo Carditis 93%

Due to Congestive Heart failure

Due to Sub Diaphragmatic abscess pleurisy with Effusion

Other conditions (Include pregnancy within 3 months of death) Perforated gall bladder

Major findings:
Of operations abscess above, liver
Of autopsy

Duration

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 H. S. Conrad (M. D. ~~or other~~)
Address Date signed

DR. H. S. CONRAD

315 KIRKPATRICK BLDG. ST. JOSEPH, MO.

NAME

ADDRESS DATE

℞ Mass was in region of Gallbladder but abd. was not opened. We assumed the pus above liver had come from the Gall bladder & the mass was an abscess -

autopsy was refused M. D.

Dr. H. S. Conrad

REGISTRY NO.