

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25397

FILED AUG 14 1941

Registration in District No. 448

Primary Registration District No. 5608

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County. Laclede Union, Mo
(b) City or town. Phillipsburg
(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. 1 (Specify whether
In this community. 1 years, months or days)

3. (a) PRINT FULL NAME John Thos Barrett

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

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

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

alive years

7. Birth date of deceased July 9 1941
(Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

12. Name Lawrence Barrett

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

14. Maiden name same

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

16. (a) Informant Lawrence Barrett

(b) Address Phillipsburg mo

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

(c) Place: burial or cremation New Hope Cemetery

18. (a) Signature of funeral director No Funeral Director

(b) Address

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

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Laclede

(c) City or town Phillipsburg mo Rural
(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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1941 hour 11 minute P M.

21. I hereby certify that I attended the deceased from July 9 1941
to July 9 1941

that I last saw him alive on July 9 1941
and that death occurred on the date and hour stated above.

Immediate cause of death

Pneumonia

Due to about 6 1/2 months

Due to Pneumonia Rupture

Other conditions membrane

(Include pregnancy within 3 months of death)

Major findings: Of operations 160C

Of autopsy

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 Grace Price (M. D. or other)

Address Phillipsburg mo Date signed 7-11-41

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 7,
District File Number 8/14/1528
Date Filed 8/12/44

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.....

No Embalming....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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

NEW YORK

WRITE PLAINLY—USE INK

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 25397Registration District No. 448Primary Registration District No. 5608

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Laclede
(b) City or town Lebanon
(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)3. (a) PRINT
FULL NAME John I Barrett

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

4. Sex m 5. Color or g race _____
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 _____ 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) 8-8-41 (b) Grace Price
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____

- that I first saw him _____ 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 sta-
tistically.

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)

- (b) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature _____ (M. D. or other) _____

- Address _____ Date signed _____

RECORD NO. BLACK INK—MAKE A PERMANENT RECORD

S-25397