DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27574

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3232

1. PLACE OF DEATH:

(a) County: JACKSON

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

(c) Name of hospital or institution: KANS. CITY CONVALESCENT HOME
(If not in hospital or institution, write street number or location)

(d) Length of stay: In ~~hospital~~ or institution / In this community 39 YRS. / 4 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 048

(c) City or town: Independence
(If outside city or town limits, write "RURAL")

(d) Street No. 515 So Osage
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME: CHARLES S. BARRON

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: MALE

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed.

6. (b) Name of husband or wife: Unknown

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

7. Birth date of deceased: ~~Aug~~ (Month) ~~26~~ (Day) ~~1941~~ (Year)

8. AGE: about

Years	Months	Days	If less than one day
83	5	18	..... hr. ..... min.

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

10. Usual occupation: Carpenter, Retired.

11. Industry or business: —

FATHER
12. Name: Solomon BARRON
13. Birthplace: Unknown. (City, town, or county) (State or foreign country) U

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

16. (a) Informant: Roy V. BARRON
(b) Address: 516 - So Osage St.

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof: 8-28-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Mound Grove.

18. (a) Signature of funeral director: Carson Funeral Home
(b) Address: 711 W. Lexington, Independence

19. (a) 8/28/41 (Date received by local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug day: 26 year: 1941 hour: 1520 minute: a M.

21. I hereby certify that I attended the deceased from 6-27-41, 19..., to 8-26-41, 19..., that I last saw him alive on 8-26-41, 19..., and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to: Arteriosclerosis	
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: O. P. Laurenance (M. D. or other)

Address: 320 Northside Date signed: 8-27-41

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3991

P. O. Address 5725 Virgi

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

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

No. 2B
—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Ch 12 MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27574

Registration District No. 399 6-27 Primary Registration District No. 1002 Registrar's No. 3232

1. PLACE OF DEATH:

(a) County: Jackson Mo.

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

(c) Name of hospital or institution: K.C. Convalescent Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution From June 27, 1941 to Aug. 28, 1941 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Jackson

(c) City or town: Independence
(If outside city or town limits, write "RURAL")

(d) Street No. 515 S. Crane
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Charles S. Barrow

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: Wid.

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

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) Burial (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) 8/28/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 26 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19; that I last 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 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)

(b) 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY