

FILED APR 20 1942

Registration District No. 774

Primary Registration District No. 4465-

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Flat River  
(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  
years, months or days)  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois  
(c) City or town Flat River  
(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 mar day 3/12/42  
year \_\_\_\_\_ hour \_\_\_\_\_ minute 12:40 P.M.

21. I hereby certify that I attended the deceased from 3-4  
1942 to 3-12 1942

that I last saw him alive on 3-11 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death: Congenital Heart disease  
Due to HT  
Due to \_\_\_\_\_

Duration

Other conditions (include pregnancy within 3 months of death) 1572

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 W. Barron (M. D. or other) \_\_\_\_\_  
Address Flat River MO Date signed 3/13/42

3. (a) PRINT FULL NAME Walter O. Barion

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 D

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

7. Birth date of deceased Mar 4 1942  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 7 If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Flat River Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Walter Barion

13. Birthplace Washington Co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Willa Barion

15. Birthplace Madison Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Barion

(b) Address Flat River Mo.

17. (a) Buried (b) Date thereof 3 12 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Falls

18. (a) Signature of funeral director Caldwell Bros

(b) Address Flat River Mo.

19. (a) 3-12-42 (b) Byrdie S. Buhmester  
(Date received local registrar) (Registrar's signature)

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

4  
3  
2

**RECEIVED**

District Health Officer No. 43

District File Number 442-415

Date Filed 4-9-42

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**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.....

P. O. Address.....

**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.**