No. 2
-1-4-41
5-17-39
I X26390

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

D[illegible]ENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 14 1943
Registration District No. 1490

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41135

Primary Registration District No. 3033

Registrar's No.

53
1
2

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:
500 Polk St. /
(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 always.

2. USUAL RESIDENCE OF DECEASED:

53
1
2

(a) State Missouri (b) County Laclede

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

(d) Street No. 500 Polk
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Joel Nathan Barber

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 married

6. (b) Name of husband or wife Mary Barber

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased May (Month) 24 (Day) 1867 (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 21
year 1942 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov 12, 1942 to Dec 21, 1942
that I last saw him alive on Dec 21, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Paralytic Stroke — Duration

Due to Cardiac decompensation

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.

8. AGE: Years	Months	Days	If less than one day
75	6	27	hr. min.

9. Birthplace Laclede Co. (City, town, or county) Mo (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name Joel C. Barber
13. Birthplace Unknown (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Sarah Bailey
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Robt Barber
(b) Address Lebanon Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-42 (Month) (Day) (Year)
(c) Place: burial or cremation Lowry

18. (a) Signature of funeral director Palmer
(b) Address Lebanon Missouri

19. (a) Dec 26-42 (Date received local registrar) (b) Grace Roper (Registrar's signature)

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 O H Bohrer (M. D. or other) D.O.
Address Lebanon Mo. Date signed 12/24/42

1090 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 170

District File Number 12-42-182

Date Filed 1-11-42

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..... D. D. Dahmer

Licensed Embalmer No. 1161

P. O. Address Lilbourn 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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41135

Registration District No. 170 Primary Registration District No. 3033 Registrar's No.

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

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 years, months or days)
In this community always

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclede
(c) City or town Lebanon
(If outside city or town limits, write "RURAL")
(d) Street No. 520 Polk
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joel N. Barber
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 Mary 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased May 24 (Month) 1 (Day) 86 (Year)

8. AGE: Years 75 Months 6 Days 2 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 Joel a Barber
13. Birthplace (City, town, or county) Ill (State or foreign country)
14. Maiden name Lizzie Bales
15. Birthplace (City, town, or county) Mo (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

SUPPLEMENTARY

20. DATE OF DEATH: Month Dec Day 2
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.

	Duration
Immediate cause of death Paralytic Stroke	
Due to cerebral hemorrhage	
Due to	
Other conditions (Include pregnancy within 3 months of death) 83	
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) (c) Means of injury

23. Signature O. J. Bohrer (M. D. or other) D.O.
Address Lebanon Mo Date signed