

FILED FEB 9 1943 *184*

Registration District No. *184*

Primary Registration District No. *3038*

1. PLACE OF DEATH:

(a) County *Linn*
(b) City or town *Brookfield*
(c) Name of hospital or institution: *1*
(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 *Mo* (b) County *Linn*
(c) City or town *Brookfield*
(If outside city or town limits, write "RURAL")
(d) Street No. *Mo 409 Peck*
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME *BONNIE ANN BARCLAY*

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

4. Sex *F* 5. Color or race *W*

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

7. Birth date of deceased *Sept 1 - 1922*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
4 28

9. Birthplace *Brookfield Mo*
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name *Jay Richard Barclay*
13. Birthplace *Boonville Mo*
14. Maiden name *Phyllis Robinson*
15. Birthplace *Brookfield Mo*

16. (a) Informant *Mrs J. P. Barclay*

(b) Address *Brookfield Mo*

17. (a) *Burial* (b) Date thereof *Jan-30-1943*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Rose Hill*

18. (a) Signature of funeral director *Phil Funeral Chapel*

(b) Address *Brookfield Mo*

19. (a) *1-29-1943* (b) *H W Curran*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* day *28*
year *1943* hour *12* minute *45 P.* M.

21. I hereby certify that I attended the deceased from *Birth* 19 _____ to *1-28* 19 *43*
that I last saw her alive on *1-28* 19 *43*
and that death occurred on the date and hour stated above.

Immediate cause of death *Congenital heart defect, Patent foramen ovale, and malnutrition*
Duration *4 mos +*

Due to _____
Other conditions (Include pregnancy within 3 months of death) *15792*

Major findings: *None*
Of operations _____
Autopsy *None*

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 _____
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 *H W Curran* (M. D. or other) _____
Address *Brookfield Mo* Date signed _____

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

2-8

JAN 16 1945

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.