

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

Dr. Feller

6304

State File No.

Registrar's No. 131

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED MAR 6 1943

Registration District No.

Primary Registration District No. 5466

39
0
0

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Rural Campbell

(c) Name of hospital or institution:
Route # 7 Campbell Township

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 6 Months _____ (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Rural Campbell Township

(d) Street No. Campbell Township Route 7

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

If yes, name country _____

3. (a) PRINT FULL NAME Martha E. Barker

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

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife N.J. Barker 6. (c) Age of husband or wife if alive Unknown

7. Birth date of deceased Jan. 17 1872

8. AGE: Years 71 Months 0 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Mississippi County Missouri

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Madison J. West

{ 13. Birthplace Unknown Kentucky

{ 14. Maiden name Unknown Deering

{ 15. Birthplace Unknown Missouri

16. (a) Informant N.J. Barker

(b) Address Route # 7 Springfield, Mo.

17. (a) Burial (b) Date thereof Feb. 14, 1943

(c) Place: burial or cremation Catharon

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 2-13-43 (b) D. W. E. Handley

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11 year 1943 hour 3 minute _____ P. _____ M.

21. I hereby certify that I attended the deceased from 12-29 1942 to Feb. 11 1943

that I last saw her alive on Feb. 10 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac failure Duration 14.00

Due to Chronic myocarditis

Due to Bronchial asthma

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? _____

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

23. Signature C. E. Feller (M. D. or other) _____

Address Springfield, Mo. Date signed 2/12/43

984

(Licensed Embalmer's Statement on Reverse Side)

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.....

Walter E. Hameller

Licensed Embalmer No.

3808

P. O. Address.....

Springfield 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.