

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **11681**

Registration District No. **381**

Primary Registration District No. **4515-6183**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Sullivan**
(b) City or town **Rural - Palsburg**
(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) **9 yrs**

In this community _____ years, months or days

3. (a) PRINT FULL NAME **William Curtis Barron**
3. (b) If veteran, _____ name war _____
3. (c) Social Security No. **1**

4. Sex **Male** 5. Color or race **white** 6. (a) **Single**, widowed, married, divorced, widowed
6. (b) Name of husband or wife **Alice Claire** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **6** **26** **1855**
(Month) (Day) (Year)

8. AGE: Years **87** Months **7** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace **Butler Co. 1 Penn**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **William Barron**
13. Birthplace **Butler Co. 1 Penn**
(City, town, or county) (State or foreign country)
14. Maiden name **Margaret Belle**
15. Birthplace **Butler Co. 1 Penn**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Floyd Lee**

(b) Address **Midway, Mo.**

17. (a) **Burial** (b) Date thereof **2-11-49**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Lion Cooper Co.**

18. (a) Signature of funeral director **Glenn E. Kent's Son**

(b) Address **Green City, Mo.**

19. (a) **Feb. 10. 43** (b) **Mrs. F. D. Green**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Sullivan**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Near Milan**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **8**
year **1943** hour **7:00** minute _____ M.
21. I hereby certify that I attended the deceased from **FEB 6** to **FEB 8**, 19**43**
that I last saw him alive on **FEB 7** and that death occurred on the date and hour stated above.

Immediate cause of death **LOBAR PNEUMONIA**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **108**

Major findings: Of operations _____

Of autopsy _____

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) (Means of injury) **2**

23. Signature **H. J. Johnson** (M.D. or other) _____

Address **Green City, Mo.** Date signed **2-9-43**

Duration

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 4-43-718

Date Filed APR 13 1943

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Shrewsbury, Mass.

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.