

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31768**

FILED SEP 16 1943 50

Primary Registration District No. **5572**

Registrar's No. **124**

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural - Prairie Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Jackson Co. E. Hosp.  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days) 30 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson <sup>049</sup>  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 8404 Flora  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31st  
year 1943 hour 12:30 minute A. M.  
21. I hereby certify that I attended the deceased from 8-28, 1943, to 8-31, 1943;  
that I last saw him alive on 8-30-43, 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myo Carditis  
nephritis "chronic"  
Due to Adenoma Prostate?  
Duration 2 yrs

Other conditions (Include pregnancy within 3 months of death) 51 lb

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 \_\_\_\_\_

Signature F. B. Dailey (M. D. or Chg.)  
Address Jackson Co. Eng. Hosp. Date signed 8/31/43

8. (a) PRINT FULL NAME James David Barry

3. (b) If veteran, name war None 8. (c) Social Security 487-1-8271

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lillian Barry 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Feb. 20 1873  
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 31 If less than one day hr. min.

9. Birthplace Fall City, Neb.  
(City, town, or county) (State or foreign country)

10. Usual occupation Flour Grinding

11. Industry or business Self

12. Name Patrick Barry

13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Casey

15. Birthplace Canada  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lillian Barry  
(b) Address 8404 Flora K.C. Mo.

17. (a) Burial (b) Date thereof 9/4/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Englebarrow  
(b) Address Indep end ave, Mo.

19. (a) Sept. 1, 1943 (b) F. H. Schick  
(Date received local registrar) (Registrar's signature)

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

880

---

---

**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. 2467

P. O. Address Indep. 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, above space should be left blank.