

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **32121**
Registrar's No. **2013039**OCT 11 1943
Registration District No. **211**Primary Registration District No. **5777**

1. PLACE OF DEATH:

(a) County **Miller**
(b) City or town **Rural - Equality**
(If outside city or town limits, write "RURAL" and name of township)
(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 **2 months** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **SARAH ELIZABETH BARR**3. (b) If veteran, name war. **---** 3. (c) Social Security No. **---**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **John Barr** 6. (c) Age of husband or wife if alive **---** years
7. Birth date of deceased **Aug-12-1875**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	68	28		hr. min.

9. Birthplace **Iberia Mo**
(City, town, or county) (State or foreign country)10. Usual occupation **Housekeeper**11. Industry or business **Farm**12. Name **Rufus Bailey**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)14. Maiden name **Susan Stane**
15. Birthplace **Miller Co. Mo.**
(City, town, or county) (State or foreign country)16. (a) Informant **Elsa Barr**
(b) Address **Jossumba, Mo**17. (a) **Burial** (b) Date thereof **9-11-43**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Iberia Mo**18. (a) Signature of funeral director **C. L. Carey**(b) Address **Iberia Mo**19. (a) **Sep 10** (b) **A. Wright**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Miller**
(c) City or town **Rural** (If outside city or town limits, write "RURAL")
(d) Street No. **Jossumba, Mo. R#1** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **---**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **9**
year **1943** hour **1** minute **0** M.21. I hereby certify that I attended the deceased from **Aug 8** to **Sept 9**
that I last saw her alive on **Sept 8** and that death occurred on the date and hour stated above.Immediate cause of death **Wrenia**
Due to **Chronic Nephritis**
Duration **10 days**
Due to **---** year

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations **131**

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) Means of injury **---**23. Signature **M. E. Humphrey** (M. D. or other) **P.O.**
Address **Jossumba, Mo** Date signed **9-14-43**

RECEIVED

Miller County Health Dep't.

County File Number 43-82

Date Filed 10-7-43

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.....

C. B. Boney

Licensed Embalmer No. 2694

P. O. Address. Jerma 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.