

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12339**

FILED APR 13 1943

Registration District No. **229**

Primary Registration District No. **6155**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Stone**
(b) City or town **Berryville, Ark. Rt. 1**
(c) Name of hospital or institution: **Home**
(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

3. (a) PRINT FULL NAME **Charles F. Barker**

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

4. Sex **Male** 5. Color or race **Wh.** 6. (a) Single, widowed, married. **2** divorced **Widowed**
6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **Deceased** years
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

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

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

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Barker**
13. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Joe Clifton**
(b) Address **Berryville, Rt. 1**
17. (a) **Burial** (b) Date thereof **11-9-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mc Collough Cemetery**

18. (a) Signature of funeral director **Used No. Undertaker**

(b) Address _____

19. (a) **3-5-44** (b) **Charles F. Barker**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Stone** **109**
(c) City or town **Berryville, Ark. (Rural)**
(If outside city or town limits, write "RURAL")
(d) Street No. **R. Rt. 1 Near State line**
(If rural, give location) **Alpine Gap**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **11** day **5**
year **1943** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **9-12**
to **9-11-1943**

that I last saw him alive on **9-12** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis** Duration
Chronic Heart

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy **121**
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. L. Carter** (M. D. or other) **X**
Address **Berryville** Date signed **2-23-44**

RECEIVED

District Health Officer No. 6.

District File Number 444-432

Date Filed APR 11 1944

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.