

FILED JUN 13 1944 234
Registration District No.

Primary Registration District No. 4494

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Winona, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joel Lee, Barrett
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Dec 1st 1866 6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 77 Months Days If less than one day hr. min.

9. Birthplace Oregon Co., Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name Not known 13. Birthplace Not known (City, town, or county) (State or foreign country)
14. Maiden name Not known 15. Birthplace Not known (City, town, or county) (State or foreign country)

16. (a) Informant Utto Barrett

(b) Address Winona, Mo

17. (a) Burial (b) Date thereof 5/14 44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Falling Springs, Cen

18. (a) Signature of funeral director John F. Shuman

(b) Address Mountain View, Mo

19. (a) 5-13-44 (b) Graude Hyde M.D. (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shannon
(c) City or town Winona, Mo (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12th year 1944 hour 4 minute 8 A. M.

21. I hereby certify that I attended the deceased from May 11-1944 to May 12-1944 that I last saw him alive on May 11-1944 and that death occurred on the date and hour stated above.

Immediate cause of death Natural Causes
Due to Arterio Sclerosis myocarditis
Due to

Other conditions (Include pregnancy within 3 months of death) 93 el

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) (e) Means of injury

23. Signature N. D. Kalline M.D. (Coroner) (M. D. or other)
Address Winona, Mo Date signed 5/12-1944

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.....

John F. Lunn
Licensed Embalmer No. *2516*

P. O. Address.....

Matthew Moore

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.