

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25049**

FILED JUL 20 1944

Registration District No. **75**

Primary Registration District No. **3036**

Registrar's No. **70**

1. PLACE OF DEATH:

(a) County **Lawrence**
(b) City or town **Aurora**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
158 W, Delta St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Months**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lawrence 55**
(c) City or town **Aurora**
(If outside city or town limits, write "RURAL")
(d) Street No. **158 W, Delta St**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Homer Doyle Barrett**

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Feb. 23 1944**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 3 16 hr. min.

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

10. Usual occupation **Infant**

11. Industry or business _____

MOTHER FATHER

12. Name **Elvis Barrett**
13. Birthplace **Barry County Mo. 0**
(City, town, or county) (State or foreign country)

14. Maiden name **Hazel Harris**
15. Birthplace **Barry County Mo. 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr Elvis Barrett**

(b) Address **Aurora Mo.**

17. (a) **Burial** (b) Date thereof **6/9/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Purdy Mo.**

18. (a) Signature of funeral director **J. F. King**

(b) Address **Aurora Mo.**

19. (a) **6-8-44** (b) **Clarence**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **8**
year **1944** hour **5** minute **30 P. M.**

21. I hereby certify that I attended the deceased from **April 30**
1944 to **June 8, 1944**
that I last saw him alive on **June**, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death **Malnutrition**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **158**

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 **M. D. Herron** (M. D. or other)

Address **Aurora Mo** Date signed **June 8 44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6,
District File Number 744-846
Date Filed JUL 17 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 Herman Surridge
Licensed Embalmer No. 3072
P. O. Address Aurora 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.