

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 40526FILED JAN 15 1945
Registration District No. 6Primary Registration District No. 3001Registrar's No. 31

1. PLACE OF DEATH:

(a) County AUDRAIN
(b) City or town VANDALIA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
709 W. 54 HIGHWAY
(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 ASA SAMUEL BARRETT3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race AMERICAN 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MONA BARRETT 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Nov 22 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>1</u>	<u>2</u>	hr. min.

9. Birthplace CURRYVILLE PIKE CO. MO. U
(City, town, or county) (State or foreign country)10. Usual occupation FARMING11. Industry or business RETIRED FARMER

12. Name FRANK BARRETT
13. Birthplace PIKE CO. MISSOURI
(City, town, or county) (State or foreign country)
14. Maiden name MARTILDA BARNSTETTER
15. Birthplace PIKE COUNTY MISSOURI U
(City, town, or county) (State or foreign country)

16. (a) Informant MONA BARRETT(b) Address VANDALIA MO.17. (a) BURIAL (b) Date thereof Dec. 26-44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation VANDALIA CEMETARY18. (a) Signature of funeral director G. Clyde G. Wilkey(b) Address Peabody, Mo.19. (a) See 27 1944 (b) Mallie Tugue
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County AUDRAIN
(c) City or town VANDALIA
(If outside city or town limits, write "RURAL")
(d) Street No. 709 W. 54 HIGHWAY
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country U

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24
year 1944 hour 7 minute 01 A.M.21. I hereby certify that I attended the deceased from Nov 6, 1944 to Dec 24, 1944
that I last saw him alive on Dec 24, 1944
and that death occurred on the date and hour stated above.Immediate cause of death Cancer of Liver Duration 6 mo.Due to 467
Due to _____Other conditions Coronary Thrombosis
(Include pregnancy within 3 months of death)

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) (c) Means of injury 223. Signature W. B. Waize (M. D. or other) D.O.
Address Ladonia Mo. Date signed 12-26-44

RECEIVED. M

District Health Officer No. 10

District File Number 1-45-135

Date Filed JAN 12 1945

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

Clyde Willey

Licensed Embalmer No.

3820

P. O. Address

Perry, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40526

Registration District No. 6

Primary Registration District No. 2001

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Audrain
(b) City or town Pandora
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Asa S. Banett

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

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov - 22 (Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 0 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3/23/45 (b) Mallie Fugha (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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 _____ (M. D. or other)

Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

1944

S-40526