. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 13 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

5652

State File No. 5652

Registration District No. 4

Primary Registration District No. 3007

Registrar's No. 42

1. PLACE OF DEATH:
(a) County: Butler Co.
(b) City or town: Poplar Bluff Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bronaugh Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 37 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Butler
(c) City or town: Poplar Bluff East
(If outside city or town limits write "RURAL")
(d) Street No.: 3
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William Ezra Barber
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: Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: July 4 (Month) (Day) 1872 (Year)

8. AGE: Years	Months	Days	If less than one day hr. min.
72	12	7	5

9. Birthplace: Indiana (City, town, or county) (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business
MOTHER FATHER
12. Name: Lycurgus Barber
13. Birthplace: Indiana (City, town, or county) (State or foreign country)
14. Maiden name: Mary Rannah Dufford
15. Birthplace: Indiana (City, town, or county) (State or foreign country)
16. (a) Informant: Mr. Jackson
(b) Address: Poplar Bluff, Mo.
17. (a) 2/11/45 (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation: Cane Springs Cem.
18. (a) Signature of funeral director: W. H. Isley
(b) Address: Carrington, Ark.
19. (a) 2-17-45 (Date received local registrar) (b) Belle Kirsch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 2/9/45 day 9
year 1945 hour 10 minute 00 A.M.
21. I hereby certify that I attended the deceased from Jan 2. 1945 to Feb. 9 - 1945
that I last saw him alive on 2/9 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchio-Pneumonia	2-1-45
Due to Chronic Nephritis	9-1-44
Due to Hypertension	
Other conditions (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? (Specify type of place)
While at work? (a) Means of injury
23. Signature: W. W. Morgan M.D. (M. D. or other)
Address: Poplar Bluff Mo. Date signed 2-10-45

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 345-374
Date Filed 3/8/45

NOV 28 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.....

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.