

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 13 1945

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

10169

State File No. \_\_\_\_\_

Registrar's No. 32

Registration District No. 207

Primary Registration District No. 5256

1. PLACE OF DEATH: *Maries e.*  
(a) County. *rural - Jefferson*  
(b) City or town. *none*  
(c) Name of hospital or institution: *none*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution *thirty years*  
(Specify whether years, months or days)  
In this community \_\_\_\_\_

3. (a) PRINT FULL NAME. *BEN BARRICK*

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

4. Sex *m* 5. Color or race *w*  
6. (a) Single, widowed, married, divorced *married*  
(b) Name of husband or wife *Mary Barrick*  
(c) Age of husband or wife if alive *45* years  
7. Birth date of deceased *Sept 14 1893*  
(Month) (Day) (Year)

8. AGE: Years *52* Months *4* Days *4*  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation *farmer*

11. Industry or business \_\_\_\_\_

12. Name *John Barrick*

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

14. Maiden name *Dora*

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

16. (a) Informant *Fritz Barrick*

(b) Address *Belle, Mo.*

17. (a) *burial* (b) Date thereof *3-20-45*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Belle - Mo*

18. (a) Signature of funeral director *Clyde Morton*

(b) Address *Mo*

19. (a) *3/20/45* (b) *Edna Bassett*  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State *Mo.* (b) County *Maries*  
(c) City or town *Rural* *6.3*  
(If outside city or town limits, write "RURAL")  
(d) Street No. *Jefferson* *0*  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? *0* years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *March* day *18*  
year *1945* hour *9* minute *15 A.M.*

21. I hereby certify that I attended the deceased from *March 18 1945* to *March 18 1945*  
that I last saw him alive on *March 10* and that death occurred on the date and hour stated above.

Immediate cause of death *he chronic valvular heart trouble*

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations *92d*

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) (e) Means of injury \_\_\_\_\_

23. Signature *L. A. Bunge* (M. D. or other) *MD*

Address *Bland, Mo.* Date signed *3-18-45*

RECEIVED  
District Health Officer No. 9,

District File Number.....

Date Filed 4-11-45

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

Emilio Jones Jr......, Registered Apprentice No. 373  
working under my personal supervision.

Signed.....

Victor Buescher

Licensed Embalmer No. 3701

P. O. Address Jefferson City

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.