

FILED 3 AUG 14 1945

Registration District No. Primary Registration District No. 4546

Registrar's No.

1. PLACE OF DEATH:

(a) County Worth
 (b) City or town Denver
 (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 none (Specify whether
 In this community 30 yrs years, months or days)

3. (a) PRINT FULL NAME LYCILE BARBER

3. (b) If veteran, name war 3. (c) Social Security No. 493-18-0844

4. Sex MD 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Myrtle Barber 6. (c) Age of husband or wife if alive 8 years (Month) (Day) (Year) 1908

8. AGE: Years 35 Months 8 Days 8 If less than one day hr. min.

9. Birthplace Worth Co (City, town, or county) mo 11 (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

12. Name Henry Barber

13. Birthplace Wentry Co (City, town, or county) mo 0 (State or foreign country)

14. Maiden name Clara Jones

15. Birthplace Worth Co (City, town, or county) mo 0 (State or foreign country)

16. (a) Informant Clara Barber

(b) Address Denver mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Miller Cemetery

18. (a) Signature of funeral director Brown

(b) Address Denver Mo

19. (a) July 2 1945 (Date received local registrar) (b) Mayme Riechart (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Worth 113
 (c) City or town Denver (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 June day 16 year 1945 hour 6 minute P M.

21. I hereby certify that I attended the deceased from May 10 to June 16 1945
 that I last saw him alive on June 15 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Vegetarianism of lung 241

Due to

Due to

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

Major findings: Of operations ✓

Of autopsy no 136

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? ✓

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

(Specify type of place)

While at work? (e) Means of injury ✓

23. Signature [Signature] (If D. or other)

Date signed 6/17/45

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. 2947

P. O. Address. Fenwick 1112

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.