7. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30526

FILED OCT 8 1945

Registration District No. 128 — Primary Registration District No. 2000 — Registrar's No. 776

1. PLACE OF DEATH:

(a) County: Greene

(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 715 S. Kimbrough Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ In this community: Entire life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene 39

(c) City or town: Rural - Springfield - N. Campbell Twp.
(If outside city or town limits, write "RURAL")

(d) Street No.: R.F.D. # 4 -
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: ____

3. (a) PRINT FULL NAME: MRS. BERTHA CECILIA BARRETT

3. (b) If veteran, name war: NONE

3. (c) Social Security No.: NONE

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: widowed

6. (b) Name of husband or wife: Walter Barrett

6. (c) Age of husband or wife if alive: Dec. years

7. Birth date of deceased: December (Month) 21, (Day) 1878 (Year)

8. AGE:

Years	Months	Days	If less than one day
66	9	7	hr. ____ min.

9. Birthplace: Greene County, (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: ____

FATHER

12. Name: J. O. Redfearn

13. Birthplace: ~~Tennessee~~ UNK. (City, town, or county) Tenn. (State or foreign country)

MOTHER

14. Maiden name: Catherine Johnson

15. Birthplace: ~~Missouri~~ UNK. (City, town, or county) Tenn. (State or foreign country)

16. (a) Informant: Mrs. F. A. Beyer

(b) Address: 715 S. Kimbrough Ave. - Sprd., Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/ 1/ 1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Brookline Cemetery

18. (a) Signature of funeral director: ALMA LOHMEYER FUNERAL HOME

(b) Address: 534 ST. LOUIS STREET - Sprd., Mo

19. (a) 10-1-45 (Date received local registrar) (b) B. W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 28, year 1945 hour 11 : minute 40 P. M.

21. I hereby certify that I attended the deceased from Sept 28, 1945 to Sept 28, 1945 that I last saw h. e. r. alive on Sept 28, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Occlusion of Coronary Artery — Duration (days)

Due to: ~~[illegible]~~

Due to: Arteriosclerosis — yrs.

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? ____ (e) Means of injury: ____

23. Signature: E. Allen Peters M.D. (M. D. or other)

Address: Medical Arts Bldg. Springfield, Mo. Date signed: 10-1-45

(Licensed Embalmer's Statement on Reverse Side)

JUN 24 1949

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 Lewis G. Scharpf

Licensed Embalmer No. 3802

P. O. Address Springfield, 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.