

FILED JAN 9 1946

Registration District No.

Primary Registration District No. 4267

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Odessa
(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.....
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette 54
(c) City or town Odessa 4
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location) 0
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Anna C. Barker

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

4. Sex Fe 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased May 17, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 5 14 hr. min.

9. Birthplace Near Odessa, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business.....

MOTHER FATHER { 12. Name Ross A. Barker
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Stapleton
15. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Warren Martin
(b) Address Odessa, Mo.

17. (a) Burial (b) Date thereof Nov. 3, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Barker Cem. Odessa, Mo.

18. (a) Signature of funeral director Husman-Sparks
(b) Address Odessa, Mo.

19. (a) Dec 3 1945 (b) T. L. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4 1945
year..... hour..... minute..... M.
21. I hereby certify that I attended the deceased from Jan 19 1945 to Nov 4 1945
that I last saw u alive on Nov 1 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Heart failure Duration
Aspiration
Pulmonary Hypertension

Due to.....
Due to.....
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?.....

While at work?..... (Specify type of place) (e) Means of injury:.....
23. Signature R. Schaefer (M. D. or other)
Address Odessa Date signed 11/3/45

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 1-8-46

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 _____

W.T. Sparks

_____, Registered Apprentice No. 385

working under my personal supervision.

Signed _____

Licensed Embalmer No. 2541

P. O. Address Odessa, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.