

FILED JAN 25 1948

Registration District No. 264

Primary Registration District No. 43

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Ozark
 (b) City or town Ironwood
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Dr. M. J. Haerman office 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community Life Time
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Haskell
 (c) City or town Bevier
 (If outside city or town limits, write "RURAL")
 (d) Street No. near Patterville mo
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country None

3. (a) PRINT FULL NAME VIVAN. LOIS. BARKS

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug 30 1945
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 19 hr. _____ min.

9. Birthplace Haskell Co MO
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name E R Barks
 13. Birthplace Haskell Co MO
 (City, town, or county) (State or foreign country)
 14. Maiden name Glenn Wheat
 15. Birthplace Ozark Co MO
 (City, town, or county) (State or foreign country)

16. (a) Informant Clarence Barks
 (b) Address Patterville mo

17. (a) Burial (b) Date thereof Oct 20-48
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Patterville Cemetery

18. (a) Signature of funeral director Roller Funeral Home
 (b) Address Waverlyville mo

19. (a) 11-19-48 (b) Agnes Pace
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November Day 19th
 Year 1948 hour 10 minute 45 P. M.
 21. I hereby certify that I attended the deceased from Nov 16
 1948, to Nov 19 1948;
 that I last saw her alive on Nov 19 1948;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
 Duration 3 days

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____

Major findings:
 Of operations 107
 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 _____
 Where did injury occur? _____ (City or town) (County) (State)
 (c) 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 M J Haerman (M.D. or other) MO
 Address Waverlyville mo Date signed 11-19-48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 146-88

Date Filed JAN 22 1946

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

Lawrence F. Hall

Licensed Embalmer No. 2784

P. O. Address Gainesville, Tex.

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.

2B
45
43880

State File No. Feb
Registrar's No. 2

Registration District No. 264

Primary Registration District No. 439J

1. PLACE OF DEATH:

(a) County Ozark
(b) City or town Steinville
(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 _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Uivan J. Baker

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 S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: Aug 30 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (Less than one day) _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Adair Hall (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1945 hour _____ minute _____ M. 9

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

3543