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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1432
Registrar's No. 25

FILED FEB 10 1947

Registration District No. 676 Primary Registration District No. 3026

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
Independence Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 days
(Specify whether years, months or days)

In this community 25 years
(years, months or days)

3. (a) PRINT FULL NAME JAMES O. BARR

3. (b) If veteran, name war None

3. (c) Social Security No. 495-07-0797

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Esther Mae Barr

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased April 11 1888
(Month) (Day) (Year)

8. AGE: Years 58 Months 9 Days 15
If less than one day hr. min.

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

10. Usual occupation Boner

11. Industry or business Rice Sausage Company

MOTHER FATHER

12. Name James Barr

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

14. Maiden name unknown

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

16. (a) Informant Mrs. Esther Barr

(b) Address 408 S. Denver K. C. Mo.

17. (a) burial (b) Date thereof 1-27-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound Grove Cemetery

18. (a) Signature of funeral director Geo. C. Carson Funeral

(b) Address Independence, Missouri

19. (a) 1-30-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 408 S. Denver
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27
year 1947 hour 9 minute 40 A.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Empyema of Right Chest

Due to Chronic Myocardial Infarction

Other conditions
(Include pregnancy within 6 months of death)

Major findings:
Of operations

Of autopsy See Above

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?

H. While at work (Specify type of place) (Specify type of injury)

23. Signature A. E. Harker (M. D. or other)

Address 2800 Main Date signed 1/27/47

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FEB 13 1957

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.....

Charles F. Tyler
working under my personal supervision.

....., Registered Apprentice No. *711*

Signed *John Parley*
.....

Licensed Embalmer No. *4308*

P. O. Address *Independence, 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.