

No. 2
8-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAY 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19929

State File No.

Registration District No.

370

Primary Registration District No.

6258

Registrar's No.

13

1. PLACE OF DEATH:

(a) County WAYNE
(b) City or town SILVA "RURAL"
(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 LIFETIME years, months or days

3. (a) PRINT FULL NAME CLIFFORD LEE BARKER

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SOV
6. (b) Name of husband or wife if alive EADIE SAMEL E. BARKER 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased SEPTEMBER 29, 1929
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
18 6 10 hr. min.

9. Birthplace SILVA MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business Laborer

12. Name SAMEL E. BARKER

13. Birthplace BOLLINGER Co. MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name COLE C. VANNAY

15. Birthplace WAYNE Co. MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant S. E. BARKER

(b) Address SILVA Mo

17. (a) BURIAL (b) Date thereof APRIL 10, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BOUNDS CREEK CEMETERY

18. (a) Signature of funeral director W. E. BARKER

(b) Address Greenfield, Mo

19. (a) May 17-47 (b) Mabel Beasley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County WAYNE
(c) City or town SILVA "RURAL"
(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 Apr day 9
year 1947 hour minute A M.

21. I hereby certify that I attended the deceased from Apr 1 - 1947 to death
that I last saw him alive on Apr 9th 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchiectasis Duration 1 yr.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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) (c) Means of injury

23. Signature William T. Baskin (M. D. or other)

Address Greenfield, Mo Date signed 4-11-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 547-212

Date Filed 5-20-47

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

CODER FUNERAL HOME

, Registered Apprentice No.

working under my personal supervision.

Signed

William Coder

Licensed Embalmer No. 3723

P. O. Address. PIEDMONT 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *June*

Registration District No. *870*

Primary Registration District No. *6258*

Registrar's No. *13*

1. PLACE OF DEATH:

(a) County *Wayne*
(b) City or town *Rural*
(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 years, months or days)

3. (a) PRINT FULL NAME

Clifford L Barker

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

6. (b) Name of husband or wife *None*
Not married

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

7. Birth date of deceased

Sept 29 1941

8. AGE:

Years

Months

Days

(If less than one day)

18

6

10

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country) *MO*

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(b)

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO* (b) County *Wayne*
(c) City or town *Silver Rural*
(If outside city or town limits, write "RURAL")
(d) Street No. *St Francis Inf.*
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* 9
year *1941* hour minute M.

21. I hereby certify that I attended the deceased from
that I last saw him alive on
and that death occurred on the date and hour stated above.
Immediate cause of death

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) (c) Means of injury

23. Signature (M. D. or other)

Address Date signed

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

SUPPLEMENTARY 9

S-19929