

FILED DEC 3 1947

Primary Registration District No. 3008

Registrar's No. 404

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No. 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 year 65 days
(Specify whether years, months or days) 1 year 65 days
In this community 1 year 65 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mollen 14
(c) City or town Fresno 2
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ U

3. (a) PRINT FULL NAME BARRON, ANTHONY BASCOMB

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 15
year 1947 hour 5:10 minute 17 M.
21. I hereby certify that I attended the deceased from December 9, 1946 to November 15, 1947
that I last saw him alive on November 14, 1947
and that death occurred on the date and hour stated above.

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 divorced
6. (b) Name of husband or wife D.K. 6. (c) Age of husband or wife if alive D.K. years
7. Birth date of deceased: January 18 (Month) (Day) 1865 (Year)

Immediate cause of death Hyphal Pneumonia
Due to.....
Due to.....

8. AGE: Years 82 Months 9 Days 17 If less than one day hr. _____ min. _____

9. Birthplace Dix (City, town, or county) Illinois (State or foreign country)

Other conditions Malnutrition (Include pregnancy within 3 months of death)

10. Usual occupation farmer

11. Industry or business _____

Major findings: Of operations _____ Of autopsy _____ Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Thony Barron !
13. Birthplace Dix (City, town, or county) Pennsylvania (State or foreign country)
14. Maiden name Ann Riley
15. Birthplace D.K. (City, town, or county) Dix (State or foreign country)

16. (a) Informant State Hospital No. 1 Records

(b) Address Fulton, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-47 (Month) (Day) (Year)

(c) Place: burial or cremation Interment, Mo.

18. (a) Signature of funeral director J.P. Phillips

(b) Address Fulton, Mo.

19. (a) 11-16-1947 (Date received local registrar) (b) Josie Morsickhoff (Registrar's signature)

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) _____
23. Signature D. J. C. Caldwell (Specify type of place) Mo.
Address Fulton, Missouri Date signed Nov 15 47

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

RECEIVED

District Health Officer No. 9,

District File Number

DEC 2 1947

Date Filed

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.....

James D. Phillips....., Registered Apprentice No.....
working under my personal supervision.

Signed *James D. Phillips*.....

Licensed Embalmer No. *3663*.....

P. O. Address *Cedar*.....

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.