

S. No. 30-47
M-10-47
v. 5-17-39
I 3906

FILED SEP 27 1948
Registration District No. **482**

Primary Registration District No. **3021**

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

1. PLACE OF DEATH:
(a) County Grundy
(b) City or town Wright
(c) Name of hospital or institution: Wright Hosp
(d) Length of stay: In hospital or institution 3 days
In this community 3 days

3: (a) PRINT FULL NAME Leige Lewis Barrow
3. (b) If veteran, name war. —
3. (c) Social Security No. —

4. Sex MD 5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lillian Barrow
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased Jan 22 1898

8. AGE: Years 50 Months 7 Days 24
If less than one day hr. min.

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

10. Usual occupation —

11. Industry or business farmer

12. Name Levissville Barrow

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

14. Maiden name Martha Foster

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

16. (a) Informant Lillian Barrow

(b) Address Laclede Mo

17. (a) Removal (b) Date thereof Sept 16 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crowning

18. (a) Signature of funeral director Wade funeral home
(b) Address Crowning Mo

19. (a) 9-16-48 (b) Gene Dues
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Lin
(c) City or town Laclede Mo
(d) Street No. 1
(e) Citizen of foreign country? —

20. DATE OF DEATH: Month Sept day 16
year 1948 hour 2 minute 55 P.M.
21. I hereby certify that I attended the deceased Sept 16 48
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary Thrombosis
Due to Do not know

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature —
Address —

Duration 20 min
PHYSICIAN
Underline the cause to which death should be charged statistically.

164-1948

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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 Gerald I Wash

Licensed Embalmer No. 4172

P. O. Address Browning

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.