

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 27 1957

41197

4348 State File No.

BIRTH NO. _____		REG. DIST. NO. <u>4348</u>		PRIMARY REG. DIST. NO. <u>383</u>		Registrar's No. <u>17</u>	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Wellsville</u>		c. LENGTH OF STAY (in this place) <u>2 YRS</u>		c. CITY OR TOWN <u>Wellsville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				f. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u>		b. (Middle) <u>LeRoy</u>		c. (Last) <u>BARR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 10 - 1957</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Sept 30 - 1867</u>	
9. AGE (In years last birthday) <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER - Ret.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel Barr</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Cassel</u>		14. NAME OF HUSBAND OR WIFE <u>ETHEL B. BARR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. ETHEL BARR - Wellsville Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Asian Influenza</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				481X	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21f. HOW DID INJURY OCCUR? _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>Nov. 6</u> , 1957, to <u>Nov 10</u> , 1957, that I last saw the deceased alive on <u>Nov. 10</u> , 1957, and that death occurred at <u>2 P</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Willis H. Walls M.D.</u>		23b. ADDRESS <u>Wellsville Mo</u>		23c. DATE SIGNED <u>11/14/57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>11-12-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wellsville Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Wellsville - Mo</u>	
DATE REC'D BY LOCAL REG. <u>11-15-1957</u>		REGISTRAR'S SIGNATURE <u>Leotrude Romano</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wells Funeral Home, Wellsville Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

**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 ....., Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed

*Robert J. McDonald*

Licensed Embalmer No. *4825*

P. O. Address *Willerville*

**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 embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.