DIST. No. 6

CERTIFICATE OF DEATH

11 | 49

DISTRICT OF COLUMBIA

No. OF RECORD 326506

FULL INSTRUCTIONS FOR THE GUIDANCE OF THOSE USING THIS BLANK AND SPACE FOR REMARKS MAY BE FOUND ON THE OTHER SIDE

1. PLACE OF DEATH:
No. 19 th. And C Streets Street, Southeast Section.
Name of Hospital Gallinger Municipal Duration of residence therein 2-26-30 to 3-11-30

2. FULL NAME Barr, Robert M

(a) Residence, No. Offord Hotel (Usual place of abode) Street Wash. DC (If nonresident, give city or town and State)

Length of residence in D. of C. ...... yrs. ...... mos. ...... ds. How long in U. S. if of foreign birth? ...... yrs. ...... mos. ...... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word):

5A. If married, widowed, or divorced, HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE: Years 73 | Months — | Days — | If LESS than 1 day ...... hrs. or ...... min.

8. OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Clerk
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wash. DC

PARENTS

10. NAME OF FATHER (in full) James Barr
11. BIRTHPLACE OF FATHER: City or town / State or country Pennsylvania
12. MAIDEN NAME OF MOTHER (in full) Jessica McClelland
13. BIRTHPLACE OF MOTHER: City or town / State or country Wash. DC

14. Above information furnished by Robt. Barr
Address Offord Hotel

15. Relation of informant to deceased Self

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) March 11 1930

17. I HEREBY CERTIFY, that I attended deceased from Feb-26 1930, to March 11 1930

that I last saw him alive on the a. m. of 3-11 1930

and that death occurred, on the date stated above, at 8-a. m.
The CAUSE OF DEATH* was as follows:

Sarcoma of Prostate

Unknown (duration) ...... yrs. ...... mos. ...... ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis

Unknown (duration) ...... yrs. ...... mos. ...... ds.

18. Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of operation —

Was there an autopsy? yes

What laboratory test confirmed diagnosis? None

(Signed) John Moore, M. D.

(Address) Gallinger Hospt.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Oak Hill Cemetery DATE Mar 14 1930

20. UNDERTAKER W. W. Chambers Co.

ADDRESS ...

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Form 7 H. D. C. 474