

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 211

Primary Registration District No. 5777

Registrar's No.

1. PLACE OF DEATH:

(a) County Miller
(b) City or town Equality, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution County Home 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 yrs (Specify whether years, months or days)

In this community
years, months or days

3. (a) PRINT FULL NAME JAMES DAVID BARNHART

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married 2 divorced
6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased April 15 1852
(Month) (Day) (Year)

8. AGE: Years 90 Months 11 Days 11 If less than one day --- hr. --- min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Adam M. Barnhart

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

14. Maiden name Mrs. E. Warren

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

16. (a) Informant Arthur Waite

(b) Address Jussambia, Mo

17. (a) Buried (b) Date thereof 3-28-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Meta - Mo

18. (a) Signature of funeral director O. L. Casey

(b) Address Boonia, Mo

19. (a) 3-30-43 (b) H. C. Wright
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Miller
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Jussambia - R#1
(If rural, give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 26
year 1943 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2-4-43
to 3-26, 1943;

that I last saw him alive on 3-25-43, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 4 days

Due to Arteriosclerosis

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) (e) Means of injury ---

23. Signature M. J. Owens (M. D. or other) ---
Address Jussambia, Mo Date signed 3-30-43

RECEIVED

Miller County Health Dep't.

County File Number 43-23

Date Filed 4-3-43

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..... *Chasey*

Licensed Embalmer No. *9694*

P. O. Address. *Iberia, 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.