

S. No. 2  
M-5-43  
7. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17723  
Registrar's No. 45

Registration District No. 290 Primary Registration District No. 4427

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

1. PLACE OF DEATH:  
(a) County Pulaski  
(b) City or town Waynesville, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Waynesville General Hospital  
(If not in hospital or institution, write street number or locality)  
(d) Length of stay: In hospital or institution 25 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County Pulaski 85  
(c) City or town Waynesville  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Lula Virginia Barnhill  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 8<sup>th</sup>  
year 1946 hour 1 minute 00 A.M.  
21. I hereby certify that I attended the deceased from April 10<sup>th</sup>, 1946 to May 8<sup>th</sup>, 1946  
that I last saw her alive on May 7<sup>th</sup>, 1946  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race W  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife Robert B Barnhill  
6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased Aug. 2 1882  
(Month) (Day) (Year)

Immediate cause of death Ant. retinal detachment Duration 3 weeks  
Due to cholecyctitis + surrounding adhesions chronic  
Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
58 hr. \_\_\_\_\_ min.

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.

9. Birthplace Texas County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

12. Name William Wade

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

14. Maiden name CARRIE GRAD

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

16. (a) Informant MR Robert B Barnhill

(b) Address Waynesville, Mo

17. (a) Burial (b) Date thereof 5/11/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gospel Ridge

18. (a) Signature of funeral director J. H. Hoops & Sons  
(b) Address Crocker Bldg.

19. (a) 5/15/46 (b) Lamine B. McClintock  
(Date received local registrar) (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) (Type of injury)  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Richland, Mo. Date signed 8/19/46

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**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..... *Paul B. Hoops* .....

Licensed Embalmer No. *3261* .....

P. O. Address..... *Crocker, 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.**