

FILED AUG 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23976

BIRTH NO. _____		REG. DIST. NO. <u>383</u>		PRIMARY REG. DIST. NO. <u>5655</u>		Registrar's No. <u>233</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Lauraense</u>		b. CITY (If outside corporate limits, write RURAL and give township) <u>Mt Vernon</u>		c. LENGTH OF STAY (in this place) <u>9 days</u>		a. STATE <u>Missouri</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Mt Vernon</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Marshfield</u>		b. COUNTY <u>Wright</u>		11 <u>7</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Sanatorium</u>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) <u>OSCAR</u>		b. (Middle) <u>E. Barnhouse.</u>		c. (Last) _____		6. COLOR OR RACE <u>White</u>	
(Type or Print) <u>OSCAR</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>March 19, 1888</u>		9. AGE (In years last birthday) <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Clark Barnhouse</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Saunders</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>500 01051</u>		17. INFORMANT'S SIGNATURE OR NAME <u>E. Michael, Record Clerk</u>		ADDRESS <u>Mo. State Sanatorium, Mt. Vernon, Mo.</u>	
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary tuberculosis</u>				<u>over 8 mo.</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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				<u>002X</u>	
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>7-12</u> , 19 <u>49</u> , to <u>7-20</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>7-20</u> , 19 <u>49</u> , and that death occurred at <u>8:45</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>C. C. Brasler M.D.</u>				23b. ADDRESS <u>Mt Vernon Mo</u>		23c. DATE SIGNED <u>7/20/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 22, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Seymour Cemetery</u>		24d. LOCATION (City, town, or county) <u>Seymour, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>7-26-49</u>		REGISTRAR'S SIGNATURE <u>Cecil Hendricks</u>		4/11 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Kelley-Terrill-Bergman</u>		ADDRESS _____	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFAADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED JUL 27 1949

District Health Office No. 6,

District File Number 749-872

Date Filed 7-29-49

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
Student Embalmer

Signed W. H. Kelley.....

Licensed Embalmer No. 3394.....

P. O. Address Fordland 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.