

FILED APR 20 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14337  
State File No. 3295  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Ohio</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR <b>Town of St. Louis City Hospital</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR <b>Columbus</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>En-Route City Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>494 Napoleon</b>	

3. NAME OF DECEASED a. (First) <b>Robert</b> (Type or Print)			b. (Middle) <b>Harmon</b>			c. (Last) <b>Barnett</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>April 5. 1950</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>July 4th 1902</b>		9. AGE (In years last birthday) <b>47</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mgr. Small Loan Bus.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Loan</b>				11. BIRTHPLACE (State or foreign country) <b>Cwensville, Indiana</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			

13a. FATHER'S NAME <b>Rufus H. Barnett</b>			13b. MOTHER'S MAIDEN NAME <b>Grace Harmon</b>			14. NAME OF HUSBAND OR WIFE <b>Mary Lloyd Barnett</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>269-10-7315</b>			17. INFORMANT'S SIGNATURE OR NAME <b>Mary Barnett</b>			18. ADDRESS <b>494 Napoleon, Columbus Ohio</b>		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)							
		ANTECEDENT CAUSES							
		Morbid 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.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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) <b>H 0 H 3</b>			
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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **8:58 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Patrick K. Taylor</b>			23b. ADDRESS <b>1300 Clark</b>			23c. DATE SIGNED <b>4/6/50</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>4-5-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Indianapolis, Indiana</b>		

DATE REC'D BY LOCAL REG. <b>APR 9 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Pasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>		ADDRESS <b>4700 Washington</b>	
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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.....

.....  
working under my personal supervision.

Signed.....  
Student Embalmer

Student Embalmer No.....  
Signed *Robert M. Murray*

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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.