

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8041**
Registrar's No. **230**

FILED MAR 19 1951

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lack	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bolivar, Mo. 0841	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 1/2 mile east of Bolivar	

3. NAME OF DECEASED (Type or Print) a. (First) Olma	b. (Middle) Barbarick	c. (Last) Barbarick	4. DATE OF DEATH (Month) (Day) (Year) Mar. 15, 1951
---	------------------------------	----------------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 31, 1875	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months 7 Days 15	IF UNDER 24 HRS. Hours Min.
----------------------	-------------------------------	---	---------------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Bolivar, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME Thomas Green	13b. MOTHER'S MAIDEN NAME Emaline Fowler	14. NAME OF HUSBAND, OR WIFE Charley J. Barbarick
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Odia Allison	ADDRESS Bolivar, Mo.
--	-------------------------------------	--	-----------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACME MDSCKEOTIC HEART DISEASE WITH CHRONIC AURICULAR FIBRILLATION AND CONGESTIVE FAILURE.		UNKNOWN
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		4200 F
II. OTHER SIGNIFICANT CONDITIONS Fracture of Left Hip, 1/29/51 Conditions contributing to the death but not related to the disease or condition causing death. BRONCHIAL ASTHMA		many years.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
--	--	---

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 **1/29/51**, 19**51**, to **3/15/51**, 19**51**, that I last saw the deceased alive on **3/15/51**, 19**51**, and that death occurred at **6:32 P. M.**, from the causes and on the date stated above.

22a. SIGNATURE O. J. Turner (Degree or title) M.D.	22b. ADDRESS Springfield, Mo.	22c. DATE SIGNED 3/15/51
--	--------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 18, 1951	24c. NAME OF CEMETERY OR CREMATORY Washburn Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
---	--------------------------------	---	---

DATE REC'D BY LOCAL REG. 3-16-51	REGISTRAR'S SIGNATURE W. E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE W. E. Handley	ADDRESS Blue Bolivar, Mo.
---	--	---	----------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

96
0

1919

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. Edward B. Erwin

Licensed Embalmer No. 3092

P. O. Address Salinas, Cal.

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.