S. No. 300
v. 10.48

FILED MAR 23 1953

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13003

BIRTH NO. _____ REG. DIST. NO. 352 PRIMARY REG. DIST. NO. 4518 Registrar's No. 16

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

1. PLACE OF DEATH
a. COUNTY: Taney
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hollister
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hilltop Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Taney
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hollister
d. STREET ADDRESS (If rural, give location): city

1060

3. NAME OF DECEASED (Type or Print): a. (First) James b. (Middle) M c. (Last) Barnwell

4. DATE OF DEATH (Month) (Day) (Year): March 18, 53

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Sept 23 1868
9. AGE (In years last birthday): 85 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Near Deaner Colo.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: W. C. Barnwell
13b. MOTHER'S MAIDEN NAME: Elizabeth Elrod
14. NAME OF HUSBAND OR WIFE: Not Married

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Lenie May Thomas — ADDRESS: Hollister 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ✓

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Apoplexy — 1 week
DUE TO (c): Senility

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: 4222
20. AUTOPSY? YES ☐ 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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/17, 1953, *to* 3/18, 1953, *that I last saw the deceased alive on* 3/18/53, 19__, *and that death occurred at* 4:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] HC
23b. ADDRESS: Branson Mo
23c. DATE SIGNED: 3/18/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-20-53
24c. NAME OF CEMETERY OR CREMATORY: Omaha Cemetery
24d. LOCATION (City, town, or county) (State): Omaha Ark

DATE REC'D BY LOCAL REG.: Mar 18 53
REGISTRAR'S SIGNATURE: S E Cogswell 376
25. FUNERAL DIRECTOR'S SIGNATURE: L. C. Holt Funeral Home — ADDRESS:

(Licensed Embalmer's Statement on Reverse Side)

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 S. Charles Holt, working under my personal supervision.

Student Embalmer No.....

Signed S. Charles Holt

Licensed Embalmer No. 819

P. O. Address Harrison Ark.

Signed.....
Student Embalmer

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.