

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 27 1953

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 4097 Registrar's No. 59

0191
0

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

1. PLACE OF DEATH: a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Harrisonville</u>	c. LENGTH OF STAY (in this place) <u>12 hrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Archie</u> <u>0190</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u> b. (Middle) <u>Weaver</u> c. (Last) <u>Barnard</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 15-1953</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH <u>Mar 14-1887</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR: Months _____ Days _____	IF UNDER 10 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer, retired 5 yrs.</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Cass Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		

13a. FATHER'S NAME <u>Reuben Barnard.</u>	13b. MOTHER'S MAIDEN NAME <u>Annabelle Mc Coy.</u>	14. NAME OF MARRIED OR WIFE <u>Bessie (Stevens) Barnard.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Bessie Barnard.</u> ADDRESS <u>Archie, Mo.</u>

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinomatosis of</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
	ANTECEDENT CAUSES DUE TO (b) <u>Primary bladder neoplasm.</u>		
	MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. 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 <u>181X</u>	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 May, 1947, to April 15 1953, that I last saw the deceased alive on April 10, 1953, and that death occurred at 8 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Harry B. Newton</u> (Degree or title)	23b. ADDRESS <u>Harrisonville, Mo</u>	23c. DATE SIGNED <u>4-18-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Apr. 17 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sharon Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Drexel Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Apr. 19 1953</u>	REGISTRAR'S SIGNATURE <u>Jara Barnard</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ammonson</u>	ADDRESS <u>Archie Mo.</u>
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RECEIVED
APR 25
CASE COUNTY
HEALTH DEPARTMENT

MAY 1 1950

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 *Phyllis Atkinson*

Licensed Embalmer No. *3470*

P. O. Address *Harrisonville*

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.

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