

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20569**

FILED JUL 1 - 1953

BIRTH NO. _____ REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **3000** Registrar's No. **201**

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

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1. PLACE OF DEATH a. COUNTY ADAIR			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY SCOTLAND		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KIRKSVILLE		c. LENGTH OF STAY (in this place) 9 MONTH	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MEMPHIS		0990
d. FULL NAME OF HOSPITAL OR INSTITUTION COMMUNITY NURSING HOME #2			d. STREET ADDRESS (If rural, give location) 1		
3. NAME OF DECEASED (Type or Print) a. (First) SADIE b. (Middle) (NMI) c. (Last) BARKER			4. DATE OF DEATH (Month) (Day) (Year) JUNE 20 1953		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH NOV. 30, 1871	9. AGE (in years last birthday) 81	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeping		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) SCOTLAND Co. Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME FERNANDEZ P. ISRAEL		13b. MOTHER'S MAIDEN NAME MARY U. STAHL		14. NAME OF HUSBAND OR WIFE LEWELL BARKER	
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 f. Frank Israel ADDRESS MEMPHIS 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, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DUE TO (b) renal failure DUE TO (c) congestive heart failure					
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 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) (m.)		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 Sept 26, 1952 , to June 20, 1953 , that I last saw the deceased alive on June 20, 1953 , and that death occurred at 2:42 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE (Name or title) 2 David W. Boam MD			23b. ADDRESS Kirksville Mo		23c. DATE SIGNED 6-22-53
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 6-23-1953	24c. NAME OF CEMETERY OR CREMATORY Memphis		24d. LOCATION (City, town, or county) (State) Memphis Mo
DATE REC'D BY LOCAL REG. 6-23-53		REGISTRAR'S SIGNATURE Kate Lambert		25. FUNERAL DIRECTOR'S SIGNATURE R. W. Wynn & Sons ADDRESS Memphis	

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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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Neal Payne*

Licensed Embalmer No. *2550*

P. O. Address *Memphis Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.