

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24622**

FILED **AUG 13 1953**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1001** Registrar's No. **3626**

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY OR TOWN <b>Kansas City</b> <small>(If outside corporate limits, write RURAL and give township)</small>		c. CITY OR TOWN <b>Kansas City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Malotte Nursing Home</b> <b>3217 Cleveland</b>		e. STREET ADDRESS (If rural, give location) <b>3217 Cleveland</b>	
3. NAME OF DECEASED (Type or Print) <b>Leslie</b>		a. (First) <b>Alpheus</b>	b. (Middle) <b>Barker</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced 3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Power &amp; Light</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Wellsville Mo. D</b>
13a. FATHER'S NAME <b>Louis Barker</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Stokes</b>	14. NAME OF HUSBAND OR WIFE <b>Helen Barker</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>487-01-0712</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Carl Barker 4529 Fairmount Ave. K.C.Mo.</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES <b>Hypertension</b> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>5-1-53</b> 19____, to <b>7-21-53</b> 19____, that I last saw the deceased alive on <b>7-21-53</b> 19____, and that death occurred at <b>4:20 p.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Frank Paul Lorenzana</b>		23b. ADDRESS <b>428 S. White Ave.</b>	
23c. DATE SIGNED <b>7-21-53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>7-23-53</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Plumwood</b>		24d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>	
DATE REC'D BY LOCAL REG. <b>7-23-53</b>		REGISTRAR'S SIGNATURE <b>Geraldine Smith</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. C.L. Forster</b>		ADDRESS <b>Kansas City Mo.</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 ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 3599  
P. O. Address J. C. M. Co.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.