No. 300
10.48

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

STANDARD CERTIFICATE OF DEATH

State File No. 30966

FILED SEP 21 1953

BIRTH NO. _____ REG. DIST. NO. 11 PRIMARY REG. DIST. NO. 5043 Registrar's No. 63

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

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Barry
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Seligman
d. STREET ADDRESS (If rural, give location): 0050 0

3. NAME OF DECEASED (Type or Print)
a. (First): Clara
b. (Middle): Jane
c. (Last): Barnes

4. DATE OF DEATH (Month) (Day) (Year): Sept. 5, 1953

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 19, 1870
9. AGE (In years last birthday): 83 — If under 1 year: Months / Days — If under 1 hr.: Hours / Min.

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

13a. FATHER'S NAME: Elin M. Dent
13b. MOTHER'S MAIDEN NAME: Tabitha Galyn
14. NAME OF HUSBAND OR WIFE: Joseph Barns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): x
16. SOCIAL SECURITY NO.: No.
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Mrs. Eunice Hensley Seligman, 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 — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteria sclerosis
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 4201
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* Sept 5, 1953, *to* Sept. 5, 1953, *that I last saw the deceased alive on* Sept. 5, 1953, *and that death occurred at* 10:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dr Chas. R. Brown MD
23b. ADDRESS: Seligman Mo.
23c. DATE SIGNED: Sept. 10-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/10/53
24c. NAME OF CEMETERY OR CREMATORY: New Salem Cemetery
24d. LOCATION (City, town, or county) (State): Seligman, Mo.

DATE REC'D BY LOCAL REG.: 9-17-1953
REGISTRAR'S SIGNATURE: Grace Williams 10-0
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Miller Funeral Home Pea Ridge, Ark.
Ralph Miller

(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 .....

....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Winford Crowdale

Licensed Embalmer No. 866

P. O. Address Rogers, Ark.

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

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