

FILED MAY 17 1954

STANDARD CERTIFICATE OF DEATH

State File No. **15190**BIRTH NO. _____ REG. DIST. NO. **58** PRIMARY REG. DIST. NO. **5216** Registrar's No. **7**

1. PLACE OF DEATH a. COUNTY CARTER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CARTER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL Pike Twp		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - Pike Twp 0180	
c. LENGTH OF STAY (in this place) 52 yrs		d. STREET ADDRESS (If rural, give location) R. Route Fremont, MO	
d. FULL NAME OF HOSPITAL OR INSTITUTION R. Route Fremont, MO			

3. NAME OF DECEASED (Type or Print) a. (First) TROY b. (Middle) ALLEN c. (Last) BARNES		4. DATE OF DEATH (Month) (Day) (Year) MAY 9, 1954	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT 13 1901
9. AGE (In years last birthday) 52	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	11. BIRTHPLACE (State or foreign country) CARTER Co. MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME SAMUEL BARNES		13b. MOTHER'S MAIDEN NAME MILLIE NORTON		14. NAME OF HUSBAND OR WIFE MARY BELE BARNES	
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 ADDRESS MARY BARNES FREMONT 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis INTERVAL BETWEEN ONSET AND DEATH 59 months ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) 002X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 **3-12-**, 1946, to **May 9**, 1954, that I last saw the deceased alive on **OCT 17, 1953**, and that death occurred at **2:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank Rucinski D.D.		23b. ADDRESS Van Buren, MO		23c. DATE SIGNED 5-10-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAY 11, 1954		24c. NAME OF CEMETERY OR CREMATORY GREEN MOUNTAIN	
24d. LOCATION (City, town, or county) (State) CARTER County MO					

DATE REC'D BY LOCAL REG. MAY 11-1954		REGISTRAR'S SIGNATURE Mrs Oeta Henson		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS COLEMAN McSPADDEN VAN BUREN, MO	
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(Licensed Embalmer's Statement on Reverse Side)

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

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 Walter C. McAllister

Licensed Embalmer No. 4543

P. O. Address West Branch, Mo.

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.