

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36316

State File No.

OCT 19 1954 FILED

BIRTH NO.		REG. DIST. NO. <u>370</u>		PRIMARY REG. DIST. NO. <u>12541</u>		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>WAYNE</u> b. CITY OR TOWN <u>RURAL (CEDAR CREEK)</u> c. LENGTH OF STAY (in this place) <u>45 YRS.</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>COLDWATER</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>WAYNE</u> c. CITY OR TOWN <u>RURAL (CEDAR CREEK TOWNSHIP)</u> d. STREET ADDRESS (If rural, give location) <u>COLDWATER, MO. 110</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JACOB</u> b. (Middle) <u>COLUMBUS</u> c. (Last) <u>BARRETT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 12, 1954</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>SEPT. 18, 1872</u>		9. AGE (In years last birthday) <u>82</u>		10. UNDER 1 YEAR Months <u>—</u> Days <u>24</u>	
11. BIRTHPLACE (State or foreign country) <u>MADISON COUNTY, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>BENTON BARRETT</u>		13b. MOTHER'S MAIDEN NAME <u>PERNIECE BARRETT</u>	
14. NAME OF HUSBAND OR WIFE <u>IDA BARRETT</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>LENN BARRETT - COLDWATER, 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, asphyxia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>organic heart disease</u> 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. INTERVAL BETWEEN ONSET AND DEATH <u>years</u>		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)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
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 <u>1950</u> , to <u>Oct</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>54</u> , and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above.		23a. SIGNATURE <u>O.R. Meyer M.D.</u> (Degree or title)	
23b. ADDRESS <u>Coldwater, Mo.</u>		23c. DATE SIGNED <u>10/14/54</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>10/14/54</u>	
24c. NAME OF CEMETERY OR CREMATOR <u>BARRETT CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>WAYNE COUNTY, MO.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Adair</u>		25. ADDRESS <u>FREDERICK TOWN, MO.</u>	
DATE REC'D BY LOCAL REG. <u>10/15/54</u>		REGISTRAR'S SIGNATURE <u>Bella Ward</u>		495		50	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
OCT 18 1954
WAYNE CO. HEALTH CENTER
FILE No. _____

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 Raymond A. Wilson

Licensed Embalmer No. 4884

P. O. Address Fredricktown, 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.