

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21551

FILED AUG 8 - 1955

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 75 PRIMARY REG. DIST. NO. 3015 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY OR TOWN <u>Cameron</u>		c. CITY OR TOWN <u>Cameron</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>5 1/2 days</u>		e. STREET ADDRESS (If rural, give location) <u>403 E Prospect</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Cameron Community Hosp</u>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Andy</u>	b. (Middle) _____	c. (Last) <u>Barnard</u>	(Month) <u>7</u>	(Day) <u>29</u>	(Year) <u>55</u>

5. SEX <u>M</u>	6. COLOR (OR RACE) <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 11 - 1874</u>	9. AGE (In years last birthday) <u>81</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 MIN. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Hamburg Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Cuttendon Barnard</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Gene Gutchen</u>	14. NAME OF HUSBAND OR WIFE <u>Lozzie Barnard</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>Lost</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. E. Otto Cameron</u>	ADDRESS <u>Cameron</u>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		<u>1 week</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>331X</u>		
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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 20, 1953, to July 29, 1955, that I last saw the deceased alive on July 29, 1955, and that death occurred at 11 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. Kunes</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Cameron Mo.</u>	23c. DATE SIGNED <u>8-3-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 1 - 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenland</u>	24d. LOCATION (City, town, or county) (State) <u>Cameron Mo.</u>
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DATE REC'D BY LOCAL REG. <u>8-3-55</u>	REGISTRAR'S SIGNATURE <u>Winifred W. Moser</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Poland Farnum</u>	ADDRESS <u>Home Cameron</u>
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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.....  
Signature of Student Embalmer

Signed..... *Robert F. Poland*

Licensed Embalmer No..... *47*

P. O. Address..... *222 West 37th St  
Camden*

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.