

FILED NOV 10 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33075**  
**4666**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

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>WORTH</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Grant City</b>	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) <b>10 weeks</b>		e. STREET ADDRESS (If rural, give location) <b>X X X</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4109 Paseo</b>		<b>1130 J</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Sarah</b> b. (Middle) <b>M.</b> c. (Last) <b>Barber</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 29, 1955</b>		
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Aug. 30, 1868</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>X X</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Worth County Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S</b>

13a. FATHER'S NAME <b>Thomas Murphin</b>		13b. MOTHER'S MAIDEN NAME <b>Hannah Comer</b>		14. NAME OF HUSBAND OR WIFE <b>Samuel N. Barber</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Duane Ewing, Sedalia Mo.</b>	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of the Stomach</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>	
ANTECEDENT CAUSES Morbid 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. <b>Generalized arteriosclerosis</b>		<b>15 1/2</b> <b>2 years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from August 1, 1955, to 29 Oct, 1955, that I last saw the deceased alive on 29 Oct, 1955, and that death occurred at 11:15AM from the causes and on the date stated above.

23a. SIGNATURE <b>Blaine Z. Hibbard</b> (Degree or title) <b>MD</b>		23b. ADDRESS <b>411 Nichols Rd KCMo</b>		23c. DATE SIGNED <b>30 Oct 55</b>	
24a. BURIAL CREMATION (REMOVAL) (Specify) <b>Burial</b>		24b. DATE <b>Oct. 31 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Isadora</b>	
		24d. LOCATION (City, town, or county) (State) <b>Worth County Mo.</b>			

DATE REC'D BY LOCAL REG. <b>10-30-55</b>		REGISTRAR'S SIGNATURE <b>Neva Marshall</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wagner Funeral Home Kansas City Mo.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

110 Emergency Room

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 Abrie R. Hansen

Licensed Embalmer No. 410

P. O. Address B. C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.