

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39571**

FILED DEC 28 1955

BIRTH NO. _____		REG. DIST. NO. <u>10</u>		PRIMARY REG. DIST. NO. <u>3002</u>		Registrar's No. <u>245</u>	
1. PLACE OF DEATH a. COUNTY <u>Andrain</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mexico, Mo.</u> c. LENGTH OF STAY (in this place) <u>6 days</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Andrain Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Andrain</u> c. CITY OR TOWN <u>Rural, (cuisse)</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>2 mi. E. of Laddonia, Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Clyde</u> b. (Middle) <u>Eugene</u> c. (Last) <u>Barnard</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 11, 1955</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>March 30, 1890</u>	
9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Elmer Barnard</u>		13b. MOTHER'S MAIDEN NAME <u>Effie Farthing</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Lula Barnard</u>	
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>—</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lula Barnard</u> ADDRESS <u>Laddonia, 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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute ASPHYXIA</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>PULMONARY HEMORRHAGE</u> DUE TO (c) <u>BRONCHIOGENIC CARCINOMA</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>162X</u>			
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 <u>June</u> , 1952, to <u>DEC 11</u> , 1955, that I last saw the deceased alive on <u>DEC 11</u> , 1955, and that death occurred at <u>3 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>William W. Jones D.O.</u>				23b. ADDRESS <u>Laddonia, Mo.</u>		23c. DATE SIGNED <u>Dec. 13, 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec. 13, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Laddonia Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Laddonia, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Dec 13-1955</u>		REGISTRAR'S SIGNATURE <u>Blanche Neely</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. W. Dienhoff</u> ADDRESS <u>Laddonia, Mo.</u>			

(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 *Clyde C. Wicker*
Licensed Embalmer No. *382*
P. O. Address *Penn.*

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.