

Health,  
Welfare  
Public  
Service

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 21 1956

31876  
STATE FILE NUMBER  
7864

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Williamson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>St. Louis, Mo.</u> Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Johnston City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> Length of stay in lb _____		d. STREET ADDRESS (If outside, give location) <u>1409 Davis</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Kate</u> Middle <u>NMN</u> Last <u>Barnes</u>			4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 5 1884</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Cartersville, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alek King</u>			14. MOTHER'S MAIDEN NAME <u>Unavailable</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>None</u>		17. INFORMANT <u>Frank Barnes, Johnston City, Ill.</u> Address _____		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma of vulva with wide-spread metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____

21. I attended the deceased from August 13, 1956 Aug. 24, 1956 and last saw her Aug. 24, 1956 alive on \_\_\_\_\_  
Death occurred at 6:55 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>C. P. McMillan, M.D.</u> (Degree or title)	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>8/25/56</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-25-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Cemetery</u>	23d. LOCATION (City, town, or county) <u>Johnston City, Illinois.</u>
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, 4700 Washington</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>AUG 25 1956</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Elmer R. Cadwell*.....

Licensed Embalmer No. *40*.....

P. O. Address *Sh. Lou*.....

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