

FILED APR 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12001

STATE FILE NUMBER

Health,
Welfare
Public
Service

Registration District No. 6

Primary Registration District No. 5031

Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Farber</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			c. CITY OR TOWN <u>Farber</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 1/2 Mils. N of Farber</u> Length of stay in lb <u>5 yrs</u>			d. STREET ADDRESS (If outside, give location) <u>1 1/2 mls. N. of Farber</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Harvey</u> Last <u>Barnes</u>			4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17, 1879</u>		9. AGE (In years last birthday) <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Brick Plant</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Barnes</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</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>492-09-146</u>	17. INFORMANT Address <u>Mrs. Holliday Ball Farber, Missouri</u>		
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>Transition and Debilitation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Chronic Circulatory Failure</u> DUE TO (c) <u>Arteriosclerosis and old age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4500</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>2 yrs.</u>
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 <u>7:30</u> Month, Day, Year <u>April 1957</u> a. m. <u>7:30</u> 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 <u>June 1952</u> to <u>April 1957</u> and last saw him alive on <u>4-6-57</u> Death occurred at <u>7:30</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>W. William W. Jones D.O.</u>		22b. ADDRESS <u>Ladonia, Mo</u>		22c. DATE SIGNED <u>4-8-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-8-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Farber Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Farber, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>William W. Jones, Ladonia, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>April 9 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mallie Fugue</u>	

(Licensed Embalmer's Statement on Reverse Side)

securing the medical certification in the specific manner required by law.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-56
0040

6-10

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. Wickes*
Licensed Embalmer No. *318*

P. O. Address *Perry*

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.