

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38906

FILED NOV 12 1957

STATE FILE NUMBER

Registration District No. 357 Primary Registration District No. 4517 Registrar's No. 90

V. S. 300  
Rev. 1-57

10660

Securing the nearest contributor in the specific manner required by 193.140 MO RS 1949.  
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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Janez Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Stone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brandon Mo</u>		c. CITY OR TOWN <u>Reeds Spring</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Skaggs Hosp</u>		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle _____ Last <u>Barnes</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>71</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 22-1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state of country) <u>Douglas Co. Mo</u>
13a. FATHER'S NAME <u>James Barnes</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Jane Cagidill</u>	14. NAME OF HUSBAND OR WIFE <u>Marion F. Barnes</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Y, N, or, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>487-24-8809A</u>	17. INFORMANT <u>Delbert Barnes - Reeds Spring</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>Cerebral Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u>		<u>unk.</u>	
DUE TO (c) _____		<u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>331X</u>	
20c. TIME OF INJURY Hour _____ g.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <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>Aug 55</u> to <u>11-1-57</u> and last saw her alive on <u>11-1-57</u> Death occurred at <u>4:30 AM</u> <u>11-1-57</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. C. Magnus, M.D.</u>		22b. ADDRESS <u>Branson, Mo</u>	
22c. DATE SIGNED <u>11-7-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov 3-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eisenham Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Reeds Spring Mo.</u>
24. FUNERAL DIRECTOR <u>Emeritt J. Cheatham - Galena Mo</u>		25. DATE RECD. BY LOCAL REG. <u>11-9-57</u>	26. REGISTRAR'S SIGNATURE <u>Helen Campbell</u>

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 *Everett J. Cheatham* .....

Licensed Embalmer No. *3870* .....

P. O. Address *H-alena Mo* .....

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.