

pt. Health,  
, & Welfare  
S. Public  
lth Service

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41591  
STATE FILE NUMBER  
Registration District No. 501 Primary Registration District No. 6032 Registrar's No. 2410

0910  
S. 300  
v. 1-57  
C

|                                                                               |  |                                                                                                                                           |                                                                                                                                             |
|-------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>RIPLEY</b>                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>RIPLEY</b> |                                                                                                                                             |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>DONIPHAN</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                      | c. CITY OR TOWN <b>DONIPHAN</b> 0910<br>Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                |
| c. FULL NAME OF (If NOT in hospital, give location)<br><b>COMMUNITY HOSP.</b> |  | Length of stay in lb<br><b>1 HR.</b>                                                                                                      | d. STREET ADDRESS (If outside, give location)<br><b>RURAL</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|                                                                                                   |                               |                                                                                                                                                             |                                                                      |                                                                       |                                               |
|---------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------|
| 3. NAME OF DECEASED (Type or print)<br>First <b>AARON</b> Middle <b>EDWARD</b> Last <b>BARNES</b> |                               |                                                                                                                                                             | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>31</b> Year <b>1957</b> |                                                                       |                                               |
| 5. SEX <b>MALE</b>                                                                                | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUG 20, 1891</b>                              |                                                                       | 9. AGE (In years last birthday) <b>66</b>     |
|                                                                                                   |                               | 10. USUAL OCCUPATION (Give kind of work done during most of year (If retired, give if retired))<br><b>RETIRED R.R. ENGINEER</b>                             |                                                                      | 11. BIRTHPLACE (City and state or country)<br><b>ROBERTSPALE IND.</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |

|                                                                                                                       |  |                                                   |  |                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|---------------------------------------------------------------|--|
| 13a. FATHER'S NAME<br><b>BENJAMIN BARNES</b>                                                                          |  | 13b. MOTHER'S MAIDEN NAME<br><b>MATILDA YOUNG</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>MRS. KATHERINE BARNES</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give dates of service)<br><b>YES 1911-1916</b> |  | 16. SOCIAL SECURITY NO.<br><b>4500</b>            |  | 17. INFORMANT<br><b>MRS. KATHERINE BARNES - DONIPHAN, MO.</b> |  |

|                                                                                                                                                         |  |  |                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b>                                                |
| Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.<br>DUE TO (b) <b>Cardiac decompensation</b>                 |  |  |                                                                                                   |
| DUE TO (c) <b>generalized atherosclerosis</b>                                                                                                           |  |  |                                                                                                   |
| 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?<br>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.) |  |
| 20c. TIME OF INJURY<br>Hour _____ Month, Day, Year _____<br>a.m. _____ p.m. _____                         |  |                                                                                              |  |

|                                                                                                                                                                                                                                                             |  |                                                                                          |  |                                                 |                                    |                      |  |                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|-------------------------------------------------|------------------------------------|----------------------|--|------------------------------------|--|
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 20f. CITY, TOWN, OR LOCATION<br><b>DONIPHAN</b> |                                    | COUNTY<br><b>MO.</b> |  | STATE<br><b>MO.</b>                |  |
| 21. I attended the deceased from <b>10/31/57</b> to <b>10/31/57</b> and last saw her <sup>him</sup> alive on <b>10/31/57</b><br>Death occurred at <b>11:40</b> <b>PM</b> on the date stated above; and to the best of my knowledge, from the causes stated. |  |                                                                                          |  |                                                 |                                    |                      |  |                                    |  |
| 22a. SIGNATURE<br><b>Frank C Johnson MD</b> (Physician or Jailer)                                                                                                                                                                                           |  |                                                                                          |  |                                                 | 22b. ADDRESS<br><b>Doniphan Mo</b> |                      |  | 22c. DATE SIGNED<br><b>11-3-57</b> |  |

|                                                                     |  |                                  |  |                                                                |                                                   |                                                               |                                                     |         |  |
|---------------------------------------------------------------------|--|----------------------------------|--|----------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------|---------|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>          |  | 23b. DATE<br><b>Nov. 3, 1957</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DONIPHAN CEMETERY</b> |                                                   | 23d. LOCATION (City, town, or county)<br><b>DONIPHAN, MO.</b> |                                                     | (State) |  |
| 24. FUNERAL DIRECTOR<br><b>EDWARDS FUNERAL HOME - DONIPHAN, MO.</b> |  |                                  |  |                                                                | 25. DATE RECD. BY LOCAL REG.<br><b>11-13-1957</b> |                                                               | 26. REGISTRAR'S SIGNATURE<br><b>Frank C Johnson</b> |         |  |

Doctor, co signer, 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  
MEDICAL CERTIFICATION

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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 *Stuart Herrent* .....

Licensed Embalmer No. *4809* .....

P. O. Address *Weyer, 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.