

Dept. Health,
uc., & Welfare
I. S. Public
Health Service
47807

V. S. 300
Rev. 1-57

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.

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47807

STATE FILE NUMBER

Registrar's No. 17

FILED JUN 30 1958

Registration District No. 142 Primary Registration District No. 5537

1. PLACE OF DEATH a. COUNTY Howell		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howell	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Peace Valley TOWN Peace Valley		c. CITY OR TOWN Peace Valley Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) 12 days	
3. NAME OF DECEASED (Type or print) First Middle Last John William Barnes		4. DATE OF DEATH Month Day Year January 16, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1878
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (City and state or country) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME A. W. Barnes		13b. MOTHER'S MAIDEN NAME Harriett Byer	
14. NAME OF HUSBAND OR WIFE Norma Jane Barnes		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Evelyn Barnes, West Plains, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of face DUE TO (b) Melanoma to Cervical DUE TO (c) gland PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Jan 1955 191X	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <input type="checkbox"/> NOT WHILE 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 Jan 1955 to Jan 16 1957 and last saw her alive on Jan 2 1955 Death occurred at Jan 16 1957 on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Ed Cooper MD	
22b. ADDRESS Thayer Mo.		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-18-1957	
23c. NAME OF CEMETERY OR CREMATORY Redburn Cemetery		23d. LOCATION (City, town, or county) (State) Oregon County, Missouri	
24. FUNERAL DIRECTOR Elmer Carter		25. DATE RECD. BY LOCAL REG. Jan 16-23-1958	
26. REGISTRAR'S SIGNATURE Laura Mitchell			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUN 30 1958

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 _____

Licensed Embalmer No. 4516

P. O. Address _____

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.