

Health,
Welfare
Public
Service

FILED MAR 5 - 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-004764

STATE FILE NUMBER

Registration District No. 59

Primary Registration District No. 4097

Registrar's No. 28

019
300
1-57

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, or TOWNSHIP only) OR <u>Harrisonville</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Harrisonville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <u>Memorial Hospital</u> INSTITUTION		Length of stay in lb <u>2 Days</u>	d. STREET ADDRESS (If outside, give location) <u>Suburban</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES NEWTON BARNARD</u>			4. DATE OF DEATH Month Day Year <u>Feb 25 1958</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26 1868</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Cass Co. Mo. U.S.A.</u>	12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Barnard</u>	13b. MOTHER'S MAIDEN NAME <u>Hestella Arnold</u>	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
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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>CHAS E. BARNARD</u> Address <u>Peculiar Mo</u>
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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>BRONCHOPNEUMONIA RT. LUNG</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>
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Conditions, if any, which gave rise to above cause (c), stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

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"/>
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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>491X</u>
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20c. TIME OF INJURY Hour Month, Day, Year p.m.	
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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
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21. I attended the deceased from <u>FEB. 24 1958</u> to <u>FEB. 25 1958</u> and last saw her alive on <u>FEB. 25 1958</u> Death occurred at <u>8:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>W. Moody M.D.</u> (Degree or title)	22b. ADDRESS <u>HARRISONVILLE Mo.</u>	22c. DATE SIGNED <u>2-26-58</u>
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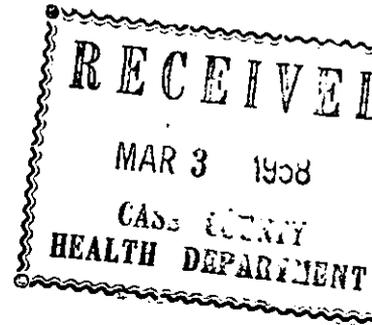
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 28-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wells Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Peculiar Mo</u>
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24. FUNERAL DIRECTOR <u>Funerary Service Harrisonville Mo</u> ADDRESS	25. DATE REC'D. BY LOCAL REG. <u>Feb 28 1958</u>	26. REGISTRAR'S SIGNATURE <u>Dora Barnard</u>
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(Licensed Embellisher's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



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 *James R. Phillips*

Licensed Embalmer No. *4641*

P. O. Address *Harrisonville*

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.