

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027952

STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

300  
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUL 21 1958 Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 54

1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SULLIVAN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MILAN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MILAN</u> <u>1050</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SULLIVAN CO MEMORIAL HOSP</u>		Length of stay in 1b <u>13 DAYS</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>BELLE</u> Last <u>BARNETT</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>10</u> Year <u>1958</u>
5. SEX <u>FEMALE</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>JAN 7 1871</u>
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Blue kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>COLCHESTER ILL 1 U.S.A</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>HENRY J IRVING</u>	
14. MOTHER'S MAIDEN NAME <u>PATRICIA M. DONOUGH</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>NONE</u>		17. INFORMANT Address <u>MRS AZ CARSON TENNESSEE ILL</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>Fracture left femur</u> <u>carcinoma liver</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> 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 <u>6-26-58</u> <u>9030H 20</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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>Fell over bucket in home</u>		20c. TIME OF INJURY Hour <u>9</u> <u>PM</u> Month, Day, Year <u>6-26-58</u>	
20d. INJURY OCCURRED WHILE AT WORK <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.) <u>about home</u>	
20f. CITY, TOWN, OR LOCATION <u>Milan Sullivan MO</u>		20g. COUNTY <u>Sullivan MO</u>	
20h. STATE <u>MO</u>		21. I attended the deceased from <u>6-26-58</u> to <u>7-10-58</u> and last saw her alive on <u>7-10-58</u> Death occurred at <u>1:15</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>E. W. Higgins D.O.</u>		22b. ADDRESS <u>Milan</u>	
22c. DATE SIGNED <u>7-11-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>JULY 12, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD</u>	
23d. LOCATION (City, town, or county) <u>MILAN</u>		23e. STATE <u>MO</u>	
24. FUNERAL DIRECTOR <u>Legg Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>7-12-58</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>		27. ADDRESS <u>Milan MO</u>	

(Licensed Embalmer's Statement on Reverse Side)

525

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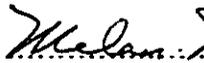
STATEMENT BY LICENSED EMBALMER

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  .....

Licensed Embalmer No. 37

P. O. Address  .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Embalmers 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.