

Health,  
& Welfare  
Public  
Service

S. 300  
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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032311

*Fitch*  
FILED SEP 29 1958

STATE FILE NUMBER  
903

Registration District No. *128* Primary Registration District No. *2000*

Registrar's No. *903*

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b> <i>0396</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>2533 E. Division</b>
3. NAME OF DECEASED (Type or print) First <b>MARVIN</b> Middle <b>RANDY</b> Last <b>BARNETT</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>19,</b> Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 Sept. 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>	11. BIRTHPLACE (City and state or country) <b>Springfield, Mo.</b>
13a. FATHER'S NAME <b>Earl F. Barnett Jr.</b>		13b. MOTHER'S MAIDEN NAME <b>Frances Collins</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>Hospital Records</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Degenerative from Angioma</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Prolapsus of Cord</b> DUE TO (c) <b>7610</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</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? 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 Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT 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	COUNTY STATE
21. I attended the deceased from <b>9-18-58</b> to <b>9-19-58</b> and last saw <del>him</del> <b>xxx</b> alive on <b>9-19-58</b> Death occurred at <b>8:25</b> P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Max V. [Signature]</i>		22b. ADDRESS <b>Spgrd. Medical Bldg. Springfield, Missouri</b>	22c. DATE SIGNED <b>9-24-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-20-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>White Chapel</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
24. FUNERAL DIRECTOR <b>J.W. Klingner &amp; Co.</b>		ADDRESS <b>Spgrd. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>9-24-58</b>
		26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Name of Deceased: *[Illegible]*  
 Date of Death: *[Illegible]*  
 Place of Death: *[Illegible]*  
 Name of Embalmer: *[Illegible]*  
 License No.: *[Illegible]*  
 Address: *[Illegible]*  
 City: *[Illegible]*  
 State: *[Illegible]*  
 Zip: *[Illegible]*

**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

*[Illegible Signature]*

Signed .....

*[Handwritten Signature: Ogden Stone Jr.]*  
 Licensed Embalmer No. *476*  
 P. O. Address *[Illegible]*

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.