

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033256  
STATE FILE NUMBER

FILED SEP 17 1958 Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 169

1. PLACE OF DEATH a. COUNTY <u>Lasher</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lasher</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Carthage</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>709 Sycamore</u>		Length of stay in-ib	d. STREET ADDRESS <u>709 Sycamore</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Barnett</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>5</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1874</u>	9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Osteopath</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Osteopath</u>	11. BIRTHPLACE (City and state or country) <u>Cicero, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>William A. Barnett</u>		13b. MOTHER'S MAIDEN NAME <u>Lucy Boyd</u>		14. NAME OF HUSBAND OR WIFE <u>Baby Hall Barnett</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. John A. Barnett, Carthage, Mo.</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>Paralysis Agitans</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>					<u>unknow</u>
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? <u>0</u> YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____					
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	
21. I attended the deceased from <u>3-20-58</u> to <u>9-5-58</u> and last saw her alive on <u>9-3-58</u> Death occurred at <u>2:30</u> <u>u.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Sharon S. Patterson MD</u> (Type or title)			22b. ADDRESS <u>Carthage, Mo.</u>		22c. DATE SIGNED <u>9-5-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Sept. 8, '58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Carthage, Mo.</u>
24. FUNERAL DIRECTOR <u>Ulmer Funeral Home, Carthage, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>9-8-58</u>	26. REGISTRAR'S SIGNATURE <u>W. H. Clifton</u>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. 1958  
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.