

Health,
& Welfare
Public
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039193
STATE FILE NUMBER

FILED DEC 3 1958 Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 163

1. PLACE OF DEATH a. COUNTY CASS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CASS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HARRISONVILLE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN HARRISONVILLE
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Memorial Hospital		Length of stay in 1b 3 wks	d. STREET ADDRESS (If outside, give location) 807 S Independence
3. NAME OF DECEASED (Type or print) First Middle Last DORA BELLE BARNARD			4. DATE OF DEATH Month Day Year Nov 18 1958
5. SEX Female	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 Dec 23, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JOURNALIST		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	9. AGE (In years) Last birthday 73
13a. FATHER'S NAME William F Gray		13b. MOTHER'S MAIDEN NAME CORNELIA CROSBY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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. 496 07 0066	14. NAME OF HUSBAND OR WIFE EARL BARNARD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA PANCREAS			19. INTERVAL BETWEEN ONSET AND DEATH 3 Months
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last: DUE TO (b) _____ DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) OSTEOARTHRITIS SEVERE			
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.		20d. INJURY OCCURRED WHILE AT WORK <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 HARRISONVILLE MO.	
21. I attended the deceased from Death occurred at 6 20 1958 to Nov. 18, 1958 and last saw her/him alive on Nov. 18, 1958 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature]		22b. ADDRESS Harrisonville Mo	
22c. DATE SIGNED Nov. 20, 1958			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/21/58	23c. NAME OF CEMETERY OR CREMATORY OAKLAND Cemetery	23d. LOCATION (City, town, or county) (State) HARRISONVILLE MO.
24. FUNERAL DIRECTOR Atkinson, Ruby Harrisonville, Mo.		25. DATE RECD. BY LOCAL REG. 11-21-58	26. REGISTRAR'S SIGNATURE Franklin Anderson

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

DEC 1 1958
CASS COUNTY
HEALTH DEPARTMENT

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 *Robert Johnson*

Licensed Embalmer No. *4902*

P. O. Address *Johnson*

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.

DEC 11 1958