

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002608

STATE FILE NUMBER

ILLU FEB 3 1959 Registration District No. 316 Primary Registration District No. 6095 Registrar's No. 27

41
S. 300
1-57

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre, Mo.		c. CITY OR TOWN Farmington, Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hosp.		d. STREET ADDRESS (If outside, give location) 304 N. Long	

3. NAME OF DECEASED (Type or print) First John Middle William Last Barnes			4. DATE OF DEATH Month Jan. Day 24 Year 1959		
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5. SEX Male	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 Feb. 15, 1888	9. AGE (In years last birthday) 70	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Francois Co. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME George Barnes	13b. MOTHER'S MAIDEN NAME Amanda Hamm	14. NAME OF HUSBAND OR WIFE Anna C. Barnes
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT Anna C. Barnes Address 304 N. Long Farmington, Mo.
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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) Anteriosclerotic heart disease with Calcific aortic stenosis Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 15 yrs.
DUE TO (b) Parkeinson's Disease		
DUE TO (c) Carcinoma of Prostate		2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Parkeinson's Disease		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.)
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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
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21. I attended the deceased from Sept 1953 to 1-24-59 and last saw him alive on 1-23-59 Death occurred at 1:15 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) C.E. Carleton M.D.	22b. ADDRESS Farmington, Mo.	22c. DATE SIGNED 1-26-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 26, 1959	23c. NAME OF CEMETERY OR CREMATORY Parkview	23d. LOCATION (City, town, or county) (State) Farmington, Mo.
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24. FUNERAL DIRECTOR C.H. Cozean ADDRESS Farmington, Mo.	25. DATE RECD. BY LOCAL REG. Jan. 27, 1959	26. REGISTRAR'S SIGNATURE Ether Rudloff
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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. 409
P. O. Address Farington

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.