Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-006283
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 179 Primary Registration District No. 4291 5673 Registrar's No. 21

1. PLACE OF DEATH
a. COUNTY LINCOLN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN OLD MONROE — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY LINCOLN
c. CITY OR TOWN OLD MONROE — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First MARY Middle SUE Last BARNETT

4. DATE OF DEATH: Month JAN. Day 31, Year 1959

5. SEX: Female
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: JULY 12, 1958
9. AGE (In years last birthday) IF UNDER 1 YEAR: Months 6 Days 19 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (City and state or country): TROY, MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: CLIFFORD BARNETT
13b. MOTHER'S MAIDEN NAME: EDNA POPE
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Clifford Barnett Address: Old Monroe, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital hydrocephalus — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Spina bifida and meningocele 75% X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 WORK [ ] NOT WHILE AT WORK [ ]
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 Aug. 7, 1958 to Jan. 31, 1959 and last saw her alive on Jan. 30, 1959
Death occurred at 1:35 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert N. Hull DO
22b. ADDRESS Elsberry, Mo
22c. DATE SIGNED 2-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE FEB. 1, 1959
23c. NAME OF CEMETERY OR CREMATORY New Hope
23d. LOCATION (City, town, or county) (State) RFD - Elsberry, Mo

24. FUNERAL DIRECTOR ADDRESS O. C. Ricks ELSBERRY, Mo
25. DATE RECD. BY LOCAL REG. Feb. 17, 1959
26. REGISTRAR'S SIGNATURE Charlotte Leek

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. 4012

P. O. Address Elsberry, Mo

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.