

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017592

STATE FILE NUMBER

2374

FILED JUN 9 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2374

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <i>Kansas city</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas city</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>The Childrens Mercy Hosp.</i>		Length of stay in lb <i>3 wks</i>	d. STREET ADDRESS <i>801 Euclid.</i> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Valarie Lynn Barren</i>			4. DATE OF DEATH Month Day Year <i>5 10 59</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-25-59</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. Month Days Hours Min. <i>13 15</i>
11. BIRTHPLACE (City and state or country) <i>Grandview Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>usa.</i>	
13a. FATHER'S NAME <i>Fletcher Barren</i>		13b. MOTHER'S MAIDEN NAME <i>Sylvia Jones</i>	
14. NAME OF HUSBAND OR WIFE		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 <i>Mrs. Fletcher Barren</i> Address <i>801 Euclid.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO (b) <i>Multiple congenital abnormalities</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>7593</i>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 <i>Apr. 20-59</i> , to <i>May 10-59</i> and last saw ^{her} _{him} alive on <i>May 10 1959</i> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>R.D. Parman M.D.</i> (Degree or title)		22b. ADDRESS <i>1710 Independence ave.</i>	
22c. DATE SIGNED <i>5-10-59</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE <i>5/13/1959</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maple Hill Cemetery</i>	
23d. LOCATION (City, town, or county) <i>Kansas City, Kansas</i>		(State)	
24. FUNERAL DIRECTOR <i>Mrs. J. W. Jones</i> ADDRESS <i>440 state ave. Kans.</i>		25. DATE RECD. BY LOCAL REG. <i>5-13-59</i>	
26. REGISTRAR'S SIGNATURE <i>new minshall</i>			

Health, Welfare, Public Service

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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

R. D. Parman

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 *Eugene English*

Licensed Embalmer No. *4105*

P. O. Address *440 State*

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.

