

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018350

STATE FILE NUMBER

FILED JUN 15 1959

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 55

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-57 4

1. PLACE OF DEATH a. COUNTY Linn		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Linn	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brookfield, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Laclede, Mo. 0580 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cramer Rest Home		Length of stay in lb About yr	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Lillie Mae Barr			4. DATE OF DEATH Month Day Year June 4, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1878
9. AGE (In years last birthday) 81		10. F UNDER 1 YEAR Months 1 Days 7	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Eversonville, Mo.
12. CITIZEN OF WHAT COUNTRY? U. S.		13a. FATHER'S NAME Riley Winegar	13b. MOTHER'S MAIDEN NAME Sarah Katherine Shipley
14. NAME OF HUSBAND OR WIFE George Barr		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. None
17. INFORMANT Lourie Clough		Address Brookfield Mo.	
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>Myocardial infarction - cardiac arrest</u> DUE TO (b) <u>Fracture left hip</u> DUE TO (c) <u>general inanition</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443XF</u>			INTERVAL BETWEEN ONSET AND DEATH <u>800 2 weeks</u> <u>2 weeks</u>
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.)		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 1958 to 1959 and last saw him alive on June 4, 1959 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE B.D. Howell M.D.	
22b. ADDRESS Brookfield Mo		22c. DATE SIGNED 6-6-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 6, 1959	
23c. NAME OF CEMETERY OR CREMATORY Laclede Cemetery		23d. LOCATION (City, town, or county) (State) Laclede, Missouri.	
24. FUNERAL DIRECTOR Brothers Funeral Home - Laclede, Mo. Blake K. K. K.		25. DATE RECD. BY LOCAL REG. 6-6-59	
26. REGISTRAR'S SIGNATURE Katharine Johnson			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

vector, coroner, etc. must use only standard nomenclature in their reports. No symptoms, signs, or test results. 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 *Blake Glidden* .....

Licensed Embalmer No. *5019* .....

P. O. Address *Leeds 27* .....

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.