

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 13 1959 **290**

59-026208

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **93**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Pulaski				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Waynesville		Length of stay in lb 6 hrs.		c. CITY OR TOWN Swedeberg		Inside Limits Yes ☐ No ☒	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Waynesville Hospital		Inside Limits Yes ☒ No ☐		d. STREET ADDRESS (If outside, give location) 2 mi. S.W.		Reside on Farm Yes ☒ No ☐	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Barker Last Barker				4. DATE OF DEATH Month Aug. Day 3, Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐	8. DATE OF BIRTH 12-21-1914	9. AGE (last birthday) 44	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shoe factory		10b. KIND OF BUSINESS OR INDUSTRY factory		11. BIRTHPLACE (City and state or country) Grovesprings, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME John Barker		13b. MOTHER'S MAIDEN NAME Della Huckleby		14. NAME OF HUSBAND OR WIFE none			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 487-22-4909		17. INFORMANT Address Waynesville Hospital, Waynesville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, vaginal, severe DUE TO (b) Carcinoma, cervical, & DUE TO (c) generalized carcinomatosis. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown	
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐	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 March 3-59 to Aug 3-59 and last saw her alive on Aug 3-1959 Death occurred at 8 p. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Shepherd, M.D.				22b. ADDRESS Richland Mo.		22c. DATE SIGNED 8-3-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 8-6-59		23c. NAME OF CEMETERY OR CREMATORY O'Dell Cemetery		23d. LOCATION (City, town, or county) (State) Grovesprings, Mo.	
24. FUNERAL DIRECTOR T.J. Shadel, Lebanon, Missouri		ADDRESS		25. DATE RECD. BY LOCAL REG. 8-3-59		26. REGISTRAR'S SIGNATURE Eula Mae Anderson	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 2848

P. O. Address W. H. S. S. S.

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.