

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028698

Registration District No. 128 FILED VS SEP 14 1959 Primary Registration District No. 2000 Registrar's No. 951 STATE FILE NUMBER

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Polk | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield | | Length of stay in 1b | c. CITY OR TOWN Humansville |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Ruffin Rest Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | | |
|--|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First ETHEL Middle CLARA Last BARBER | | | 4. DATE OF DEATH Month September Day 7 Year 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 23 Jan. 1884 | 9. AGE (last birthday) 75 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | 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 Home | 11. BIRTHPLACE (City and state or country) Horton, Kansas | 12. CITIZEN OF WHAT COUNTRY USA |
|---|--|---|---|

| | | |
|---|---|--|
| 13a. FATHER'S NAME Elizah B. Pruitt | 13b. MOTHER'S MAIDEN NAME Caroline F. Berry | 14. NAME OF HUSBAND OR WIFE Deceased |
|---|---|--|

| | | | |
|--|--------------------------------------|--|------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. No | 17. INFORMANT Mrs. Howard Voyles | Address Humansville, Mo. |
|--|--------------------------------------|--|------------------------------------|

| | | |
|---|---------------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | Arteriosclerotic heart disease | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | general arteriosclerosis | |
| 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) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

| | | |
|---|---|--|
| 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 1:30 a.m. p.m. | Month, Day, Year |
|---|------------------|

| | | | | |
|--|--|--|-----------------------|--------------------------|
| 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 Humansville | COUNTY Polk | STATE Missouri |
|--|--|--|-----------------------|--------------------------|

21. I attended the deceased from **Dec '58** to **9/7/59** and last saw her alive on **Sept 2, 1959**
Death occurred at **1:30 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|--|---------------------------------------|
| 22a. SIGNATURE Don J. Silaby MD | 22b. ADDRESS Springfield, Missouri | 22c. DATE SIGNED SEP 9 1959 |
|---|--|---------------------------------------|

| | | | |
|--|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9/9/59 | 23c. NAME OF CEMETERY OR CREMATORY Humansville Cemetery | 23d. LOCATION (City, town, or county) (State) Humansville, Mo. |
|--|----------------------------|---|--|

| | | | |
|--|------------------------------------|--|---|
| 24. FUNERAL DIRECTOR Beckwith Funeral Home | ADDRESS Humansville, Mo. | 25. DATE RECD. BY LOCAL REG. 9-10-59 | 26. REGISTRAR'S SIGNATURE Effie G. Melton |
|--|------------------------------------|--|---|

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 Glen D. Williams

Licensed Embalmer No. 465

P. O. Address Springfield

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.