

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029538

FILED VS AUG 18 1959

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 123

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Oklahoma</u> b. COUNTY <u>TULSA</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webb City</u>		Length of stay in 1b		c. CITY OR TOWN <u>Tulsa</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1228 W. Daugherty</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1440 E. 37th.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Darling</u> Last <u>Barnes</u>				4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1959</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-28-1890</u>	9. AGE (last birthday) <u>68</u>	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) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Greenfield Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>William H. Dunbar</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Potter</u>			14. NAME OF HUSBAND OR WIFE <u>Ben Barnes- Died 1940</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ralph W. Barnes, 1228 W. Daugherty, Webb City</u>				Address <u>Mo.</u>
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>Coronary Occlusion</u> DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 MIN.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Hypertension</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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		COUNTY		STATE	
21. I attended the deceased from <u>6-18-48</u> to <u>Present</u> and last saw <u>her</u> alive on <u>8-11-59</u> Death occurred at <u>7:10</u> <u>a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>W. W. Forbes, D.O.</u> (Degree or title)					22b. ADDRESS <u>106 S. Main St. Webb City, Mo.</u>			22c. DATE SIGNED <u>8-14-59</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-15-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sarcoxie Cemetery</u>			23d. LOCATION (City, town, or county) <u>Sarcoxie Missouri</u>				
24. FUNERAL DIRECTOR <u>Hedge-Lewis Funeral Home, Webb City Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>8-15-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Madeline Switzer</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 Richard Gray Law

Licensed Embalmer No. 4400

P. O. Address Webb City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.