URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–030232

STATE FILE NUMBER

FILED VS SEP 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7677

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis
Length of stay in 1b: 4 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St.John's Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Mississippi
c. CITY OR TOWN: Bertrand
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Route 1
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: David Middle: Paul Last: Barnett
4. DATE OF DEATH: Month: August Day: 15, Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11/7/1904
9. AGE (last birthday): 54
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Dalton,Ark.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Lee Barnett
13b. MOTHER'S MAIDEN NAME: Temple Stubblefield
14. NAME OF HUSBAND OR WIFE: Ruth
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 492-42-2451
17. INFORMANT: Basil Barnett, Address: Rt., East Prairie,Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Bladder neck obstruction
DUE TO (c): 606X
INTERVAL BETWEEN ONSET AND DEATH

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 Aug 11, 59, to Aug 15 59 and last saw him alive on Aug 15, 1959
Death occurred at 11:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] (Degree or title) M.D.
22b. ADDRESS: 3720 Washington
22c. DATE SIGNED: Aug 17 59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 8-18-59
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town, or county) (State): Charleston,Mo.

24. FUNERAL DIRECTOR: Albert H.Hoppe,Inc., ADDRESS: 4700 Washington Blvd
25. DATE RECD. BY LOCAL REG.: AUG 18 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. C.P.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 J Wm Burbaley

Licensed Embalmer No. 365

P. O. Address St Lou

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