

URR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035070

FILED VS OCT 26 1959

3002

206

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Audrain</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Audrain</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mexico</b>		Length of stay in 1b		c. CITY OR TOWN <b>Vandalia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Audrain Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1117 S. Central</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Karen</b> Middle <b>Sue</b> Last <b>Barr</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>8</b> Year <b>1959</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-8-52</b>	9. AGE (last birthday) <b>7</b>	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)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Hannibal, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Earl Barr</b>			13b. MOTHER'S MAIDEN NAME <b>Dorothy Mae Terry</b>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Earl Barr, Vandalia Mo.</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Congenital heart Disease</b> DUE TO (c) <b>Lipo chondrodystrophy</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Congenital</b> <b>Congenital</b>		
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 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 <b>10-7-59</b> to <b>10-8-59</b> and last saw her alive on <b>10-8-59</b> Death occurred at <b>9:30 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>William B Waters</b>				22b. ADDRESS <b>Mexico Mo</b>			22c. DATE SIGNED <b>10-10-59</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-10-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Vandalia Cemetery</b>		23d. LOCATION (City, town, or county) <b>Vandalia, Mo.</b>		(State)		
24. FUNERAL DIRECTOR <b>William B Waters Vandalia Mo</b>				25. DATE RECD. BY LOCAL REG. <b>Oct. 10. 1959</b>		26. REGISTRAR'S SIGNATURE <b>Blanche Neely</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF OHIO

DEPARTMENT OF HEALTH

No. \_\_\_\_\_ Date \_\_\_\_\_  
 Name of Deceased \_\_\_\_\_  
 Residence \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Cause of Death \_\_\_\_\_  
 Date of Death \_\_\_\_\_  
 Place of Death \_\_\_\_\_  
 Name of Physician \_\_\_\_\_  
 Name of Coroner \_\_\_\_\_

**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 William Blatter

Licensed Embalmer No. 4169  
 P. O. Address Vandalia, Mo.

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.