

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-038583

FILED VS OCT 3 0 1959

STATE FILE NUMBER

Registration District No. 325 Primary Registration District No. 4480 Registrar's No. 2539

ENDED

1. PLACE OF DEATH a. COUNTY <u>Schenck</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Schenck</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Greentop</u>		c. CITY OR TOWN <u>Greentop</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b		Inside Limits Yes ☒ No ☐	
		Reside on Farm Yes ☐ No ☒	

3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Mabel</u> Last <u>Barnhart</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>21</u> Year <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH <u>12-24-92</u>
10a. USUAL OCCUPATION (Give kind of work done during/most of working life, even if retired) <u>Nursemaid</u>		11. BIRTHPLACE (City and state or country) <u>Tanawana Mo</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Charles Alphonse McClintock</u>		13b. MOTHER'S MAIDEN NAME <u>Shirley Ann Anderson</u>		14. NAME OF HUSBAND OR WIFE <u>James Barnhart</u>	
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 <u>Jim Barnhart</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>Myocardial Failure</u> DUE TO (b) <u>Transition</u> DUE TO (c) <u>Carcinoma of Liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>3 mo.</u> <u>1 yr.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>Cholecystitis</u>		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.) <u>-</u>	

20c. TIME OF INJURY Hour <u>-</u> a.m. <u>-</u> p.m. <u>-</u>		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.) <u>-</u>		20f. CITY, TOWN, OR LOCATION <u>Queen City, Mo.</u>		COUNTY <u>Mo</u> STATE <u>Mo</u>	
21. I attended the deceased from <u>8/23/50</u> to <u>10/21/59</u> and last saw her alive on <u>10/20/59</u>		Death occurred at <u>1:25 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							

22a. SIGNATURE <u>Edward M. Roberts, M.D.</u>		22b. ADDRESS <u>Queen City, Mo.</u>		22c. DATE SIGNED <u>10/24/59</u>	
23a. DATE <u>Oct 25 '59</u>		23b. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		23c. LOCATION (City, town, or county) (State) <u>Lavonia Mo</u>	
24. FUNERAL DIRECTOR <u>A. Stiles Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>10-25-59</u>		26. REGISTRAR'S SIGNATURE <u>Bar P. Decker</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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Licensed Embalmer No. 4619

P. O. Address Queen City

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.