

FRI NOV 3 0 1959
URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039610
 STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1270

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		c. CITY OR TOWN <u>SPRINGFIELD</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>220 COURT</u>	

3. NAME OF DECEASED (Type or print) First <u>KENTON</u> Middle <u>DOUGLAS</u> Last <u>BARNARD</u>			4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-59</u>	9. AGE (last birthday) <u> </u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>26</u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (City and state or country) <u>Greene Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
13a. FATHER'S NAME <u>KYLE D. BARNARD</u>		13b. MOTHER'S MAIDEN NAME <u>GLENDIA M. DYE</u>		14. NAME OF HUSBAND OR WIFE <u>NO</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. <u>NO</u>		17. INFORMANT <u>MRS. GEORGE HOLT STRAFFORD, MO.</u>	
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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) <u>Respiratory Failure</u>			<u>2 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<u>Cerebral Hemorrhage & Edema</u>	<u>3 days</u>
	DUE TO (c)	<u>Accidental Trauma</u>	<u>3 days</u>
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Child thrown from automobile</u>
20c. TIME OF INJURY <u>10:00</u> p.m. Month, Day, Year <u>11 21 59</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. CITY, TOWN, OR LOCATION <u>Greene County</u>	COUNTY <u>MO.</u>	STATE <u>MO.</u>
21. I attended the deceased from <u>11-21-59</u> to <u>11-24-59</u> and last saw her/him alive on <u>11-24-59</u> Death occurred at <u>3:25</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Douglas Barnard MD</u> (Degree or title)		22b. ADDRESS <u>Springfield Mo.</u>		22c. DATE SIGNED <u>11-25-59</u>
23a. BURIAL, CREATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-27-59</u>	23c. NAME OF CEMETERY OR CREMATOR <u>PANTHER VALLEY Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>WEBSTER Co. MO.</u>	

24. FUNERAL DIRECTOR <u>Robert Bergman Bergman, mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

0417-1199

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 Max L. Miller

Licensed Embalmer No. 4720

P. O. Address Windsfield

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.