

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-040918**

**FILED VS NOV 24 1959**

700

Primary Registration District No. 3041

Registrar's No. 193

STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Macon</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Macon</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Macon</b>		Length of stay in 1b		c. CITY OR TOWN <b>Macon</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>525 N. Missouri</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>525 N. Missouri</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>John</b> Middle <b>Samuel</b> Last <b>Barney</b>				<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>11</b> Year <b>1959</b>					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3/3/1876</b>	<b>9. AGE (last birthday)</b> <b>83</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Paris Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>			
<b>13a. FATHER'S NAME</b> <b>Benjamin Barney</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Monson</b>			<b>14. NAME OF HUSBAND OR WIFE</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, go, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>B.W. Barney</b>		Address <b>Macon, Mo.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Intestinal Virus infection</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Not definite</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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year								
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	COUNTY	STATE					
<b>21. I attended the deceased from</b> <b>Nov 10 - 1959</b> <b>to</b> <b>Nov 11 - 1959</b> <b>and last saw him alive on</b> <b>Nov 11, 1959</b> Death occurred at _____ <b>9</b> <b>a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
<b>22a. SIGNATURE</b> (Degree or title) <b>Howard Miller MD</b>			<b>22b. ADDRESS</b> <b>Macon</b>			<b>22c. DATE SIGNED</b> <b>11/13/59</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>11/13/1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Memorial Gd.</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Macon Missouri</b>					
<b>24. FUNERAL DIRECTOR</b> <b>R. Lester Brown</b>			ADDRESS <b>Macon, Mo.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>11/18/59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Steth Neely</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

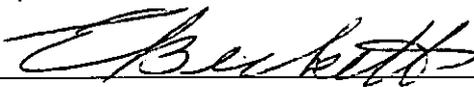
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 3227

P. O. Address Mason M.

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.