

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005170

FILED VS. FEB. 9 1960 042

Primary Registration District No. 1000

Registrar's No. 225

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>50 Yrs</b>	c. CITY OR TOWN <b>St. Joseph</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>St. Joseph's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2314 Francis St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>AUGUST</b> Middle <b>F.</b> Last <b>BARMANN Sr.</b>			4. DATE OF DEATH Month <b>February</b> Day <b>22,</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-27-1884</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. (2) Plumber</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Plumbing</b>	11. BIRTHPLACE (City and state or country) <b>Savannah, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Cornelius Barmann</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Kathryn Bier</b>		14. NAME OF HUSBAND OR WIFE <b>Clara Barmann</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>500-07-3995</b>	17. INFORMANT Address <b>A.F. Barmann Jr. St. Joseph, Mo.</b>		
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><i>duodenal ulcer</i></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</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 _____ a.m. _____ p.m. _____	Month, Day, Year				
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 <u><i>JAN 1960</i></u> to <u><i>2-22-60</i></u> and last saw her/him alive on <u><i>2-22-60</i></u> Death occurred at <u><i>11:30 P</i></u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deaf or title) <i>Clement C. Sherman</i>			22b. ADDRESS <i>St Joseph Mo</i>		22c. DATE SIGNED <i>2-25-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-25-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Joseph, Mo.</b>	(State)	
24. FUNERAL DIRECTOR <i>H.D. Lindeman &amp; Son</i> <i>R.X.Y.</i>		ADDRESS <i>St Joseph, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>Feb. 24, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>	

DOCUMENT

C.C. DuMont, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Summit*

**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 *Robert H. Gape*

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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