URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-011625
STATE FILE NUMBER

ENDED FILED VS MAR 22 1960 Registration District No. 170 Primary Registration District No. — Registrar's No. 53

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Laclede
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Spring Hollow
Length of stay in 1b: 30 Years
c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION: Route #3, Lebanon
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Laclede
c. CITY OR TOWN: Lebanon
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Route #3 Lebanon, Mo
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Wlliam Middle: Ralph Last: Barnes

4. DATE OF DEATH: Month: March Day: -14 Year: -1960

5. SEX: M

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-25-1887

9. AGE (last birthday): 72
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): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (City and state or country): Marshfield, Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Milton W. Barnes

13b. MOTHER'S MAIDEN NAME: Mary Blankenship

14. NAME OF HUSBAND OR WIFE: Grace Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes World War 1

16. SOCIAL SECURITY NO.: 493-01-6118-A

17. INFORMANT: Mrs. Grace Barnes Rt.#3 Lebanon, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CHRONIC VALVULAR HEART DISEASE
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): CHRONIC GLOMERULONEPHRITIS
DUE TO (c): —
INTERVAL BETWEEN ONSET AND DEATH: 2 (MONTHS)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): BRONCHITIS

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.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

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.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-22-60 to 3-14-60 and last saw him alive on 3-13-60
Death occurred at 1:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Dr. A. R. Knauss D.O.

22b. ADDRESS: Lebanon, Mo.

22c. DATE SIGNED: 3/16/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-16-60

23c. NAME OF CEMETERY OR CREMATORY: Lebanon City

23d. LOCATION (City, town, or county) (State): Lebanon Mo.

24. FUNERAL DIRECTOR: S. R. Palmer ADDRESS: Palmer Funeral Home-Lebanon, Mo.

25. DATE RECD. BY LOCAL REG.: 3-17-1960

26. REGISTRAR'S SIGNATURE: Nella L. Hay

(Licensed Embalmer's Statement on Reverse Side)

MAR 23 196

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed S. R. Palmer

Signature of Student Embalmer

Licensed Embalmer No. 2208

P. O. Address Lebanon K

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