

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-014009

FILED VS MAR 28 1960 378

4552

11-

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Wright</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mtn. Grove</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mtn. Grove Rest Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Texas</u> c. CITY OR TOWN <u>Summersville</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
--	--	---	--

3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Thurlow</u> Last <u>Barnes</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/14/83</u>	9. AGE (last birthday) <u>76</u>	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) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Pattersonville, Mo</u>		
13a. FATHER'S NAME <u>John Henry Barnes</u>		13b. MOTHER'S MAIDEN NAME <u>Syrena Cropper</u>		14. NAME OF HUSBAND OR WIFE _____		

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>none</u>	17. INFORMANT <u>J.H. Barnes</u> Address <u>Summersville, Missouri</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>Arteriosclerosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Several months</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 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 checked="" 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 2-1-60 to 2-5-60 and last saw ^{her}him alive on 2-5-60
 Death occurred at 3:15 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) _____	22b. ADDRESS <u>Mtn. Grove Mo.</u>	22c. DATE SIGNED <u>2-7-60</u>
---	------------------------------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2/8/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Summersville, Mo.</u>
--	-------------------------	---	--

24. FUNERAL DIRECTOR <u>Duncan Funeral Home</u> ADDRESS <u>Mtn. View, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-5-1960</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
---	--	--

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard A. Hart

Licensed Embalmer No. 502

P. O. Address Mt. Vernon

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.