

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015137

FILED VS MAY 16 1960 149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 2365 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>6 yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5115 Garfield</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5115 Garfield</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>DAVID</b> Last <b>BARKER</b>				4. DATE OF DEATH Month <b>4</b> Day <b>27</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5 6 1874</b>		9. AGE (last birthday) <b>85</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during <del>life</del> working life, even if retired) <b>Ret. Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Odessa, Missouri</b>			12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>				
13a. FATHER'S NAME <b>Stephen Barker</b>				13b. MOTHER'S MAIDEN NAME <b>Sarah Stephenson</b>				14. NAME OF HUSBAND OR WIFE <b>Cassie Allred Barker</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>456-07-2297</b>		17. INFORMANT Address <b>Mrs. Helen King 5115 Garfield</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) <b>Carcinoma of the Lung</b>										INTERVAL BETWEEN ONSET AND DEATH <b>months</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____													
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 <b>March 26 - 1960</b> to <b>4-27-1960</b> and last saw him alive on <b>4-27-1960</b> Death occurred at <b>8:20/PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Arthur W. Winkelman MD</i>						22b. ADDRESS <b>7449 Broadway</b>				22c. DATE SIGNED <b>4-28-60</b>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4 30 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odessa Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>Odessa Missouri</b>						
24. FUNERAL DIRECTOR ADDRESS <b>Floral Hills Memorial Chapels, Inc</b>				25. DATE RECD. BY LOCAL REG. <b>4-28-60</b>		26. REGISTRAR'S SIGNATURE <i>Helen Marshall</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ESCALER WINKELMAN

*Handwritten notes in the top right corner.*

**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 *Ernest D. Coldman*

Licensed Embalmer No. 4714

P. O. Address KP 4000

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.