

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-018318

FILED VS MAY 16 1960

38

Primary Registration District No. 3006

Registrar's No. 270

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>SHANNON</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbin</u>		Length of stay in 1b <u>19 da</u>		c. CITY OR TOWN <u>WINONA</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) <u>University Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William Harold</u> Middle <u>Barkley</u> Last <u>Barkley</u>				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-13-45</u>	9. AGE (last birthday) <u>15</u>	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) <u>MINOR</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>WINONA, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13a. FATHER'S NAME <u>J. W. BARKLEY</u>			13b. MOTHER'S MAIDEN NAME <u>Ester Barkley</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>Medical Records (Chart) Columbia, Mo.</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>Increased intracranial pressure</u> DUE TO (b) <u>Chronic Arachnoiditis</u> DUE TO (c) <u>Undetermined Cause</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>26 days</u> <u>10 months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hemorrhagic tendency multiple generalized patches</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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>4/17/60</u> to <u>5/7/60</u> and last saw her him alive on <u>5/7/60</u> Death occurred at <u>7:45 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Arthur K. Legans MD U of Mo Med Center</u>				22b. ADDRESS		22c. DATE SIGNED <u>5/7/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>May 7, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>		23d. LOCATION (city, town, or county) <u>Mo.</u>				
24. FUNERAL DIRECTOR <u>Barber Funeral Service, Columbia</u>			25. DATE RECD. BY LOCAL REG. <u>May 7 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 9 1960

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

George A. Keefe

Licensed Embalmer No. 4752

P. O. Address Columbia,

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.