

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028082

FILED VS JUL 22 1960

318

1003

7019

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Oklahoma</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b	c. CITY OR TOWN <b>Ada</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>905 1/2 Towerwood</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Verona</b> Middle <b>Marie</b> Last <b>Barnes</b>			4. DATE OF DEATH Month <b>July</b> Day <b>11th</b> Year <b>1960</b>		
---	--	--	--	--	--

5. SEX <b>Female</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>6/5/1886</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
-------------------------	----------------------------------	---	-------------------------------------	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY
---	-----------------------------------	---	-----------------------------

13a. FATHER'S NAME <b>Henry F. Kleykamp</b>	13b. MOTHER'S MAIDEN NAME <b>Pauline Leinker</b>	14. NAME OF HUSBAND OR WIFE <b>Carl W. Barnes</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>Not Known</b>	17. INFORMANT <b>Rev. Fred J. Greve</b> Address <b>54 Ortolon Santa Cruz Calif</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) _____ DUE TO (b) <b>Cerebral Hemorrhage</b> DUE TO (c) _____ 331x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

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 checked="" 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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Gabriel J. Taylor</b> (Degree or title)	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>7.13.60</b>
--	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 14th/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn</b>	23d. LOCATION (City, town, or county) <b>1800 Lemay Ferry Rd.</b>
--	----------------------------------	--	--

24. FUNERAL DIRECTOR <b>Harry A. Kraeger</b>	ADDRESS <b>24 Chapel Hill</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 13 1960</b>	26. REGISTRAR'S SIGNATURE <b>Karl Smith, M.D.</b>
---	----------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

*John J. Haines*

Licensed Embalmer No. 4108

P. O. Address Shaw

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