IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

=60=030004

STATE FILE NUMBER

FILED VS SEP 12 1960

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 304

NDED

1. PLACE OF DEATH
a. COUNTY Cole
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jefferson City, Mo.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Marys Hospital
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Francois
c. CITY OR TOWN Doe Run, Mo.
Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Diane Middle: Louise Last: Barnhouse

4. DATE OF DEATH Month: Sept. Day: 4 Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/3/41
9. AGE (last birthday): 19
IF UNDER 1 YEAR: Months 1 Days 1
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Los Angelses, Calif USA
12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME: Lewis Lee Pickens
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Charles D. Barnhouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Charles D Barnhouse Address: Doe Run, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	generalized peritonitis	6 days ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	ruptured abscess of spleen	7 days ?
DUE TO (c)	?	

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

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 Sept 2 1960, to Sept 5 1960 and last saw her/him alive on Sept 5, 1960
Death occurred at 9:15 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Harold C Stricker MD
22b. ADDRESS: 515 E. High Jefferson City, Mo
22c. DATE SIGNED: 9-6-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9/6/60
23c. NAME OF CEMETERY OR CREMATORY: IOOF Cemetery
23d. LOCATION (City, town, or county) (State): Glenwood, Mo.

24. FUNERAL DIRECTOR: Sylvester Dulle ADDRESS: J C Mo.
25. DATE RECD. BY LOCAL REG.: 8 September 1960
26. REGISTRAR'S SIGNATURE: R.P. Harris, MD – N. Richter, Dep

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____

Licensed Embalmer No._____

P. O. Address_____

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