

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045244

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STATE FILE NUMBER

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

NDED

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b Lifetime		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hospital,			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Crestview Village			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mildred Middle Barkley Last Vineyard				4. DATE OF DEATH Dec. 4 , 19 60 Month Day Year							
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Jan. 15, 1895		9. AGE (last birthday) 65	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) Chairman of Board			10b. KIND OF BUSINESS OR INDUSTRY Vineyard Realty Co.		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY USA				
13a. FATHER'S NAME John O. Barkley			13b. MOTHER'S MAIDEN NAME Margaret Estelle Johnston			14. NAME OF HUSBAND OR WIFE Geo. H. Vineyard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 497-32-3470		17. INFORMANT Benjamin R. Vineyard				Address St. Joseph, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor (glioma) left mid- Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) brain area. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 15 months			
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 9/26/56 to 12/4/60 and last saw her ^{her} alive on 12/3/60 Death occurred at 8:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) Donald J. Stallard, M.D.					22b. ADDRESS 902 Edmond St.			22c. DATE SIGNED 12/8/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE December 8, 1960	23c. NAME OF CEMETERY OR CREMATORY Cremains buried Mt. Mora Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.						
24. FUNERAL DIRECTOR Meierhoffer-F leeman, Inc.				ADDRESS St. Joseph, Mo		25. DATE RECD. BY LOCAL REG. Dec. 9/1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

DOCUMENT

D. J. Stallard, Medical Certification

BY AFFIDAVIT OF

FEB 21 1963

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 Robert B. Harrington

Licensed Embalmer No. 3250

P. O. Address H. J. Jones

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.