

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-022181

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. 4427 Registrar's No. 84

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JUL 11 1961

1. PLACE OF DEATH
 a. COUNTY Pulaski
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Waynesville Length of stay in 1b 19 days
 c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri b. COUNTY Dent
 c. CITY OR TOWN Lenox Inside Limits Yes No
 d. STREET ADDRESS X (If outside, give location) Residence on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Celia Amanda Barlet
4. DATE OF DEATH Month Day Year June 25 1961

5. SEX female
6. COLOR OR RACE white
7. Married Never Married Widowed Divorced
8. DATE OF BIRTH 4-12-82
9. AGE (last birthday) 79
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) housewife
10b. KIND OF BUSINESS OR INDUSTRY X
11. BIRTHPLACE (City and state or country) Dent Co Mo
12. CITIZEN OF WHAT COUNTRY U S A

13a. FATHER'S NAME Bob Redick
13b. MOTHER'S MAIDEN NAME Celia Hamby
14. NAME OF HUSBAND OR WIFE Riley Barlet

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. X
17. INFORMANT *Delmar Barlet Address Lenox 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) Cardiac + pulmonary arrest
 DUE TO (b) cachexia + debilitation
 DUE TO (c) hypertensive + congestive heart disease
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) possible carcinoma of the uterus
 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 1960 to 1961 and last saw her ^{her} _{him} alive on June 25, 1961
 Death occurred at 1:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Type or title) B.G. Myers DO.
22b. ADDRESS Leckling, Mo.
22c. DATE SIGNED 6-26-61

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 6-28-61
23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cem
23d. LOCATION (City, town, or county) (State) Dent Co Missouri

24. FUNERAL DIRECTOR ADDRESS Spencer Funeral Home Inc, Salem, Mo. 7-8-61
25. DATE RECD. BY LOCAL REG.
26. REGISTRAR'S SIGNATURE *Emilia Appel Anderson*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

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 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.