MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

EPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-028609
STATE FILE NUMBER

ITE UB | AMENDED

Registration District No. 5-8 Primary Registration District No. 5-216 Registrar's No. 15

FILED AUG 25 1961

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED	BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: CARTER
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: PIKE TWP. — Length of stay in 1b: 70 YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: FARM RESIDENCE — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: CARTER
c. CITY OR TOWN: FREMONT — Inside Limits: Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location): FREMONT — Reside on Farm: Yes ☑ No ☐

3. NAME OF DECEASED (Type or print): First: SAMUEL Middle: ALEXANDER Last: BARNES
4. DATE OF DEATH: Month: Aug Day: 16. Year: 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 8-28-1873
9. AGE (last birthday): 87 — IF UNDER 1 YEAR: Months 11 Days 16 — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (City and state or country): SHANNON Co. MO
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: WILLIAM BARNES
13b. MOTHER'S MAIDEN NAME: LOUISE BOCKMAN
14. NAME OF HUSBAND OR WIFE: MILLIE N. BARNES
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: L. D. BARNES Address: FREMONT, MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Circulatory Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Epithelioma (multiple) — 4 yrs.
DUE TO (c):
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. ☐ 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 3-29-50 to 7-29-61 and last saw him alive on 3-23-60
Death occurred at 6:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Frank J. Rucinski, D.O
22b. ADDRESS: Van Buren, Mo.
22c. DATE SIGNED: 8-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 8-18-61
23c. NAME OF CEMETERY OR CREMATORY: EVALINE Cemetery
23d. LOCATION (City, town, or county) (State): CARTER Co. MO

24. FUNERAL DIRECTOR: McSpadden Funeral Home ADDRESS: Van Buren, Mo
25. DATE RECD. BY LOCAL REG.: Aug. 22-61
26. REGISTRAR'S SIGNATURE: Mrs Octa Henson

(Licensed Embalmer's Statement on Reverse Side)

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 Allan C. McJunkin

Licensed Embalmer No. 45-43

P. O. Address Van Buren

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.