

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032394

STATE FILE NUMBER

Registration District No. 113 Primary Registration District No. 5430 Registrar's No. 91

AMENDED

FILED OCT 13 1961

1. PLACE OF DEATH a. COUNTY <b>FRANKLIN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>CENTRAL</b>		c. CITY OR TOWN <b>UNION</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>AT HOME</b>		d. STREET ADDRESS (If outside, give location) <b>R.R. # 2</b>	

3. NAME OF DECEASED (Type or print) First <b>FRANCIS</b> Middle <b>E.</b> Last <b>BARBAUD</b>			4. DATE OF DEATH Month <b>SEPT.</b> Day <b>26</b> Year <b>1961</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 30, 1898</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ST. CLAIR, MO.</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>	
13a. FATHER'S NAME <b>FRANK BARBAUD</b>		13b. MOTHER'S MAIDEN NAME <b>ELLA COMBS</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</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>	17. INFORMANT <b>BERNIECE FELLEENZ ST. CLAIR, MO.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>5 wks</b>
DUE TO (b) <b>CORONARY Thrombosis</b>		
DUE TO (c) <b>CORONARY Insufficiency</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cerebral Ischemia</b>		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 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 <b>ST. CLAIR MO.</b>

21. I attended the deceased from **9-20-61** to **9-26-61** and last saw him alive on **9-26-61**  
Death occurred at **1:15 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>John M. Williamson D.O.</b>	22b. ADDRESS <b>445 S. Main St. St. Clair MO.</b>	22c. DATE SIGNED <b>9-27-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>SEPT. 28, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT CEM.</b>
24. FUNERAL DIRECTOR <b>OLTMANN FUNERAL HOME UNION, MO.</b>		23d. LOCATION (City, town, or county) <b>ST. CLAIR MO.</b>
25. DATE RECD. BY LOCAL REG. <b>27 Sept 1961</b>		26. REGISTRAR'S SIGNATURE <b>Shalley Smith</b>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

OCT 13 1961

**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 Ralph Ottmann

Licensed Embalmer No. 4808

P. O. Address Union, Mo.

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.