

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4802 - 61-032727  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. \_\_\_\_\_

AMENDED  
**FILED OCT 11 1961**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF JOHN D. DE MOSS

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>			Length of stay in 1b <u>2 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Neurological Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2222 E. 67th. Terr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>C.</u> Last <u>Barnert</u>			4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1961</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-23-1891</u>	9. AGE (last birthday) <u>70</u>	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) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (City and state or country) <u>Nelson, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Peter Koernig</u>			13b. MOTHER'S MAIDEN NAME <u>Molly Reutschler</u>			14. NAME OF HUSBAND OR WIFE <u>Carl Barnert</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Thatcher Funeral Home</u> Address <u>Booneville Mo</u>			
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) <u>Coronary thrombosis, acute</u>						<u>Seconds</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Generalized arteriosclerosis</u> <u>Years</u>		
DUE TO (c) <u>Rheumatic fever &amp; heart disease</u> <u>Years</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>tbc, arrested, long standing</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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		COUNTY		STATE		
21. I attended the deceased from <u>7/25/60</u> to <u>9/27/61</u> and last saw her <u>alive</u> on <u>9/27/61</u> Death occurred at <u>9:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>John D. De Moss M.D.</u>				22b. ADDRESS <u>1440 Professional Bldg</u>		22c. DATE SIGNED <u>9/27/61</u> (State) <u>Mo</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>9-27-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Paul</u>		23d. LOCATION (City, town, or county) <u>Booneville</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar</u> Woodland			25. DATE RECD. BY LOCAL REG. <u>9-27-61</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

NOV 20 1961

MAY 29 1962

Mr. Charles De 91  
Prof. C. De 91

Vi 2-5492

1:00 to 4:00

**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 Hal Thourange

Licensed Embalmer No. 3408

P. O. Address Indep., 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.