

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035642

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Primary Registration District No. 6225 Registrar's No. 153

STATE FILE NUMBER

Filed District No. 360 OCT 10 1961

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington</u>		Length of stay in 1b <u>7 Mo. 27 Days</u>	c. CITY OR TOWN <u>Reeds Springs</u>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hosp. No 3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Reeds Springs</u>

3. NAME OF DECEASED (Type or print) First <u>Barrett</u> Middle <u>Ray</u> Last <u>Barrett</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1961</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7-1890</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>/</u>	11. BIRTHPLACE (City and state or country) <u>Carrol Co. Arkansas</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Irving Barrett</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Battin</u>	14. NAME OF HUSBAND OR WIFE <u>Divorced</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>----</u>	17. INFORMANT <u>Hosp. Records</u>	Address <u>State Hosp Nevada Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u>
DUE TO (b) <u>Generalized Arteriosclerosis Tears</u>		
DUE TO (c) <u>/////</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>with Circulatory Disturbance, with Cerebral Arteriosclerosis,</u>		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	
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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.) <u>/////</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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.) <u>/////</u>	20f. CITY, TOWN, OR LOCATION <u>/////</u>	COUNTY <u>/////</u>	STATE <u>/////</u>
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21. I attended the deceased from <u>2-10-61</u> to <u>10-7-61</u> and last saw ^{him} alive on <u>10-7-61</u> Death occurred at <u>9:47 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Gilda Muzich M.S.</u>	22b. ADDRESS <u>STATE HOSP. #3 REEDS SPRING, MO</u>	22c. DATE SIGNED <u>10-7-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-7-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bonnyville Cemetery Bonnyville Ark.</u>	23d. LOCATION (City, town, or county) (State) <u>/////</u>
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24. FUNERAL DIRECTOR <u>Arthur Owen & Sons</u>	ADDRESS <u>/////</u>	25. DATE RECD. BY LEGAL REG. <u>10-7-61</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>
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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

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 _____

Floyd E. Carstairs

Licensed Embalmer No. 4419

P. O. Address E. Donald Spriggs

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.