

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037624

STATE FILE NUMBER

Registration District No. 88 Primary Registration District No. 3089 Registrar's No. 81

AMENDED FILED NOV 13 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>LINN</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>LINN</u>                           |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MEADVILLE</u>   |   | c. CITY OR TOWN <u>MEADVILLE</u>  |  |
| Length of stay in 1b <u>LIFE</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 _____  |   | d. STREET ADDRESS (If outside, give location) _____   |  |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>LILLY K. BARNES</u>  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>10-29-61</u>  |
| 5. SEX<br><u>FEMALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3-22-74</u>   |
| 9. AGE (last birthday)<br><u>87</u>  |   | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HR<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY _____   | 11. BIRTHPLACE (City and state or country)<br><u>AVALON, Mo.</u>   |
| 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |   | 13a. FATHER'S NAME<br><u>JOHN D. KELLER</u>   |  |
| 13b. MOTHER'S MAIDEN NAME<br><u>SARAH J. CARPENTER</u>   |   | 14. NAME OF HUSBAND OR WIFE<br><u>NINEVAH C.</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO. _____   |  |
| 17. INFORMANT<br><u>N.C. BARNES, MEADVILLE, Mo.</u>  |   | Address _____   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia Terminal</u>  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Coronary Sclerosis</u>   |   |   | <u>5 yrs</u>   |
| DUE TO (c) <u>Arterial Sclerosis</u>   |   |   | <u>10 yrs</u>  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |
| 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.)  |  |
| 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 checked="" 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>Jan. 10-48</u> to <u>Oct. 29-61</u> and last saw her alive on <u>Oct. 22-61</u><br>Death occurred at <u>2:00</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |
| 22. SIGNATURE (Degree or title)<br><u>Joseph C. Conrad M.D.</u>  |   | 22b. ADDRESS<br><u>Chillicothe, Mo</u>  | 22c. DATE SIGNED<br><u>Nov 26 1961</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE<br><u>11-1-61</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MEADVILLE CEMETERY</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>MEADVILLE, Mo.</u>   |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>WRIGHT'S, MEADVILLE, Mo.</u>  |   | 25. DATE RECD. BY LOCAL REG.<br><u>Nov. 9 - 1961</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Anna Watson</u>  |

**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 W. R. Wright

Licensed Embalmer No. 4655

P. O. Address Wheatville, 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.