

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040667

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Dr. Brown
 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1141

FILED NOV 28 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY BOONE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 3 HRS.	c. CITY OR TOWN HARRISON
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ROUTE # 5
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE HELEN BARNES			4. DATE OF DEATH Month Day Year NOV. 21 1961		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/23/03	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) HUMBOLT, KANSAS		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME P. E. FITZMAURICE		13b. MOTHER'S MAIDEN NAME SOPHIA HALL		14. NAME OF HUSBAND OR WIFE CECIL BARNES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT Address CECIL BARNES, RT # 5 HARRISON, ARK.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Collapse. Stopping of heart beat</i> DUE TO (b) <i>Severe pituitary deficiency secondary</i> DUE TO (c) <i>To either (1) chronic renal insufficiency or (2) primary aldosteronism</i>		INTERVAL BETWEEN ONSET AND DEATH
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <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 type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION SPRINGFIELD	COUNTY BOONE	STATE ARKANSAS
21. I attended the deceased from <u>5:30 PM</u> to <u>Nov 21</u> and last saw her/him alive on <u>Nov 21st at 7:00 P.M.</u> Death occurred at <u>8 P.M.</u> on the date stated above, and to the best of my knowledge, from the cause stated.				

22a. SIGNATURE <i>Ellie L. Brown</i> (Degree or title)	22b. ADDRESS <i>1636 S. Glendale Springfield, Mo. 65804</i>	22c. DATE SIGNED <i>Nov 21 1961</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 11/21/61	23c. NAME OF CEMETERY OR CREMATORY OMAHA
23d. LOCATION (City, town, or county) OMAHA, ARKANSAS		(State)

24. FUNERAL DIRECTOR ADDRESS H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 11-24-61	26. REGISTRAR'S SIGNATURE <i>Ellie L. Brown</i>
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ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 H. L. McCann

Licensed Embalmer No. 4727

P. O. Address Spfld ma

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.