

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043268

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. _____ Registrar's No. 43

AMENDED

FILED DEC 4 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	<u>STE GENEVIEVE</u>	a. STATE	<u>STE GENEVIEVE MISSOURI</u>
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN	<u>weingarten mo rt. #1</u>	c. CITY OR TOWN	<u>WEINGARTEN</u>
Length of stay in lb	<u>Life</u>	Inside Limits	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION	Inside Limits	d. STREET ADDRESS (if outside, give location)	Reside on Farm
	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<u>RFD RT. # 1</u>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
<u>HARRY CLINTON BARNES</u>				<u>NOV. 25 1961</u>			

5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR.
<u>MALE</u>	<u>WHITE</u>		<u>2/28/98</u>	<u>63</u>	Months	Days
					Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
<u>SALESMAN</u>	<u>SALESMAN</u>	<u>STE GENEVIEVE CO</u>	<u>U.S.A.</u>

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
<u>RICHARD BARNES</u>	<u>ALICE CORTOISE</u>	<u>NONE</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<u>NO</u>		<u>MRS TROY KENNEDY WEINGARTEN MO RT 1</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>Cerebral Apoplexy</u>	<u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive situation</u>	<u>Not known</u>
	DUE TO (c) <u>Pericardial Disease</u>	<u>20 years</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.
		<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.)
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20c. TIME OF INJURY	Hour	Month, Day, Year
	a.m. p.m.	

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
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21. I attended the deceased from Nov 21 - 1961 to Nov 25, 1961 and last saw him alive on Nov 23, 1961
 Death occurred at 10:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (If parent or title)	22b. ADDRESS	22c. DATE SIGNED
<u>George F. Wood</u>	<u>Farmington Mo</u>	<u>11/27/61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>11/29/61</u>	<u>GENEVIEVE</u>	<u>NEAR FARMINGTON MO.</u>	

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<u>C.H. COZEAN</u>	<u>FARMINGTON MO.</u>	<u>30 November 1961</u>	<u>George F. Wood</u>

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____

C. H. Cozeman

Licensed Embalmer No. 4084

P. O. Address Farrington

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.