

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-011705

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 170Primary Registration District No. —Registrar's No. 75

FILED APR 2 1962

1. PLACE OF DEATH a. COUNTY Laclede		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Laclede	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington T.S.		c. CITY OR TOWN Lebanon	
Length of stay in 1b 20 yrs.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Route #1,		d. STREET ADDRESS (If outside, give location) Rural Route #1	
3. NAME OF DECEASED (Type or print) First Dale Middle Winfield Last Barber		4. DATE OF DEATH Month March Day 22 , Year 1962	
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-19-22
9. AGE (last birthday) 39		IF UNDER 1 YEAR Months 39 Days 39 Hours 39 Min. 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (City and state or country) Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME W.R. Barber		13b. MOTHER'S MAIDEN NAME Lula Taylor	
14. NAME OF HUSBAND OR WIFE none		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT W.R. Barber, Rt. 1, Lebanon, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Palsy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Shree birth DUE TO (c) 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) Epilepsy			
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 12:15 a.m. p.m. Month, Day, Year May 3 1955			
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.) March 21 1962	
20f. CITY, TOWN, OR LOCATION Lebanon, Mo.		20g. COUNTY Laclede Co.	
20h. STATE Mo.		20i. DATE RECD. BY LOCAL REG. 3-24-62	
21. I attended the deceased from May 3 1955 to March 21 1962 and last saw him alive on June 24, 1960 . Death occurred at 12:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE J. H. Johnson (Degree or title) MD	
22b. ADDRESS Lebanon, Mo.		22c. DATE SIGNED 3-24-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3-25-62	
23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		23d. LOCATION (City, town, or county) (State) Lebanon, Laclede Co., Mo.	
24. FUNERAL DIRECTOR J. J. Shadel		25. REGISTRAR'S SIGNATURE Mella L. Hlay	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

BY AFFIDAVIT OF

APR 3 1962

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 _____

Licensed Embalmer No. 5115

P. O. Address _____

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.

Print Name 3-24-1962 D.L.H.