

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-046443

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 266

FILED JAN 2 1962

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

6365
3362
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4 0
5 1
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9420.1
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12-0
135-0

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Franklin		a. STATE Mo b. COUNTY Franklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington		c. CITY OR TOWN St. Clair	
Length of stay in lb 31 days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital		d. STREET ADDRESS (If outside, give location) 745 S. Main St.,	
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)		4. DATE OF DEATH	
First Middle Last William Arthur Barns		Month Day Year Dec. 22, 1962	
5. SEX Male	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 6/28/91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Furniture	9. AGE (last birthday) 71
11a. FATHER'S NAME David Barns		11b. BIRTHPLACE (City and state or country) Illinois	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
13a. David Barns		13b. Rose Hancock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Gertrude Barns	
14. SOCIAL SECURITY NO.		Address St. Clair, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 3 wks	
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION			
DUE TO (b) ACUTE CORONARY THROMBOSIS			
DUE TO (c) ATHEROSCLEROTIC CU DISEASE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Hypertension		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 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 COUNTY STATE	
21. I attended the deceased from 7th 1956 to 8th 1962 and last saw him alive on 12-22-62		Death occurred at 7th P m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) John J. Reed M.D.		22b. ADDRESS St. Clair, Mo.	
22c. DATE SIGNED 12-24-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/25/62	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	23d. LOCATION (City, town, or county) (State) St. Clair, Mo.
24. FUNERAL DIRECTOR ADDRESS Casey-Lenox F.H. St. Clair, Mo.		25. DATE RECD. BY LOCAL REG. 12/25/62	26. REGISTRAR'S SIGNATURE Leola C. Hutchinson

JAN 4 1963

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. M. Levitt*

Licensed Embalmer No. 3601

P. O. Address St. Clair, 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.