

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-014754

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 134

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED APR 23 1963

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Schuylers</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkville</u>		Length of stay in 1b <u>21 days</u>	c. CITY OR TOWN <u>Strentop</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>K. O. H. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Strentop</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ora</u> Middle <u>William</u> Last <u>Barnett</u>			4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1963</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-1897</u>
9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY — — —	11. BIRTHPLACE (City and state or country) <u>Mark Iowa</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>William J. Barnett</u>	
13b. MOTHER'S MAIDEN NAME <u>Amanda Morgan</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie Barnett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>NO</u>		16. SOCIAL SECURITY NO. <u>263</u>	17. INFORMANT Name <u>Minnie Barnett</u> Address <u>Strentop Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>medullary failure</u> DUE TO (b) <u>chronic brain syndrome</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Small stroke, angiotensin failure - congested</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3/22/63</u> <u>4/15/63</u>
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 <u>Strentop</u> COUNTY _____ STATE _____	
21. I attended the deceased from <u>4/13/63</u> to <u>4/15/63</u> and last saw him alive on <u>4/15/63</u> Death occurred at <u>10:15</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Milton Lee, MD</u> (Degree or title)		22b. ADDRESS <u>800 W. Jefferson St. Kirksville</u>	
22c. DATE SIGNED <u>4/16/63</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>4-17-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fugate Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Rural Strentop Mo</u>
24. FUNERAL DIRECTOR <u>Doody Funeral Home</u>	25. DATE RECD BY LOCAL REG. <u>4-16-1963</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u>	

USE BLACK INK OR TYPEWRITER RIBBON

APR 24 1963

MILAN LESKO, D.O.

Permit renewed April 15, 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 *[Signature]*

Licensed Embalmer No. 4619

P. O. Address *Princeton, 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.