

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1707 STATE FILE NUMBER **63-031462**

FILED AUG 26 1963

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY CLAY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 30 DAYS	c. CITY OR TOWN RECTOR, ARKANSAS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 106 FORDYCE STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOHN Middle COLLIER Last BARKER			4. DATE OF DEATH Month AUGUST Day 9 Year 1963		
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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 7-8-94	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) RECTOR, ARKANSAS	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME WILLIAM BARKER	13b. MOTHER'S MAIDEN NAME PHOEBE STAFFORD	14. NAME OF HUSBAND OR WIFE WINIFRED BARKER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI	16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARDIAC FAILURE		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) ESSENTIAL HYPERTENSION	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) MITRAL STENOSIS		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
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19. WAS AUTOPSY PERFORMED? YES 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.)
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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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA	20f. CITY, TOWN, OR LOCATION 7-10-63 to 8-9-63	COUNTY _____ STATE _____
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21. I attended the deceased from _____ to _____ and last saw him/her on _____ Death occurred at 10:44 a. m. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) DAVID W. MILLER, M.D., Acting Pathologist	22b. ADDRESS VA Hospital, Poplar Bluff, Mo.	22c. DATE SIGNED 8-9-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-12-63	23c. NAME OF CEMETERY OR CREMATORY Woodland Heights	23d. LOCATION (City, town or county) (State) Rector, Ark.
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24. FUNERAL DIRECTOR Inky Funeral Home, Rector, Ark.	ADDRESS _____	25. DATE RECD. BY LOCAL REG. 8/15/1963	26. REGISTRAR'S SIGNATURE Thelma Graham
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DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 1 0128
 2 8030
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 4 0
 5 1
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 7 1
 8 1
 9 9443X
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 12 5-0
 13 1-0
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 USE BLACK INK OR TYPEWRITER RIBBON

AUG 28 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 *Ran McBride*

Licensed Embalmer No. 776

P. O. Address *Fector Club*

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.