

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0025660

DO NOT WRITE ON THIS STUB

AMENDED

JNF FILED 19-64

Registration District No. 19-345 Primary Registration District No. 6284 Registrar's No. 14 STATE FILE NUMBER

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DATE AMENDED
Rev. 4/59		
1 1140		
2 1140		
3		
4 0		
5 1		
6		
7 0		
8 0		
9 1500		
10		
11		
12 90-0		
13		
	INSTEAD OF	
	DOCUMENT	
	MEDICAL CERTIFICATION	
	BY AFFIDAVIT OF	
	ITEM NO.	SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Wright</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Montgomery Township</u>		Length of stay in 1b	c. CITY OR TOWN <u>Graff, Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Graff, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural</u>
3. NAME OF DECEASED (Type or print) First <u>MARVIN</u> Middle <u>FRANCIS</u> Last <u>BARNES</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1964</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1984</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>79</u>
13a. FATHER'S NAME <u>Frank Barnes</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah Jane Goldsmith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Sarah Barnes Mtn. Grove, Mo. Wife</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>Atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
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.)		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	
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 <u>Sept 10-1964</u> to <u>6-15-64</u> and last saw ^{her} him alive on <u>6-14-64</u> Death occurred at <u>6-18-1964 12:15 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. O. Cleary M.D.</u>		22b. ADDRESS <u>Mtn. Grove Mo.</u>	
22c. DATE SIGNED <u>6-16-64</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-18-1964</u>	
23c. NAME OF CEMETERY <u>Dutch Chapel</u>		23d. LOCATION (City, town, or county) (State) <u>Wright County Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Barber Funeral Home Mtn. Grove, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-18-1964</u>	
26. REGISTRAR'S SIGNATURE <u>Donnie J. Jones</u>			

JUL 27 1964

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 George Stapp

Licensed Embalmer No. 3161

P. O. Address Mt. Airie, WCO

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.