

FILED MAY 10 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12299**

BIRTH NO. _____ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **3026** Registrar's No. **172**

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Independence		c. CITY OR TOWN Independence	
d. FULL NAME OF HOSPITAL OR INSTITUTION INdep. SAN + Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print)	a. (First) Lydia	b. (Middle) LORE	c. (Last) Barrett	4. DATE OF DEATH (Month) (Day) (Year) April 30 - 54
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 19 Sept. 1874	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) Montrose Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John W. Morris	13b. MOTHER'S MAIDEN NAME Lucy ANN DEAN	14. NAME OF HUSBAND OR WIFE W.P. Barrett.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No No	17. INFORMANT'S SIGNATURE OR NAME Julia Barger	ADDRESS Indep. Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. fracture femur		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Degeneration DUE TO (c) C Coronary Sclerosis		2 years	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201F	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4/24, 1954**, to **4/30, 1954**, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Fred Smith	(Degree or title)	23b. ADDRESS 10229 Independence Rd	23c. DATE SIGNED 4/30/54
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24a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	24b. DATE MAY - 54	24c. NAME OF CEMETERY OR CREMATORY Brookings Cem.	24d. LOCATION (City, town, or county) (State) RAY TOWN Mo.
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DATE REC'D BY LOCAL REG. 5-1-54	REGISTRAR'S SIGNATURE Russell D. ...	25. FUNERAL DIRECTOR'S SIGNATURE ... + Mitchell	ADDRESS Indep. Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Jason T. White*.....
Licensed Embalmer No. *492*.....

P. O. Address *Indep*.....

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.