

FILED MAR 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 5366

Registration District No. 172 Primary Registration District No. 5670 Registrar's No. 23

0640  
300  
7-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Rafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Rafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Davis Twp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Higginsville</u> 0540 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 mi. S.E. Higginsville - 3 mo.</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>5 mi. N.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lawrence C. Barber</u> First Middle Last		4. DATE OF DEATH <u>Mar. 1 1957</u> Month Day Year	
5. SEX <u>m</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>Feb. 13, 1925</u>
9. AGE (In years last birthday) <u>32</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Renter</u>	11. BIRTHPLACE (City and state or country) <u>Waynes, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James C. Barber</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Army 1945-49</u>	
16. SOCIAL SECURITY NO. <u>490-42-4446</u>		17. INFORMANT <u>Rosaine Barber - RR - Higginsville Mo.</u> Address	
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>Pulmonary Edema</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Aspiration pneumonia</u>			<u>2 days</u>
DUE TO (c) <u>Glioma of BRAIN</u>			<u>18 mo.</u>
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 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.) <u>2</u>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		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>Jan. 5, 1957</u> to <u>MARCH 1, 1957</u> and last saw <del>him</del> <u>him</u> alive on <u>Feb. 27, 1957</u> Death occurred at <u>FIVE-thirty a. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Edwin Wilson D.O. 2</u>		22b. ADDRESS <u>1815 Main Higginsville Mo.</u>	22c. DATE SIGNED <u>3/1/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 3, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Higginsville Mo.</u>
24. FUNERAL DIRECTOR <u>Arvid Beckhof - Higginsville Mo.</u> ADDRESS <u>March 4-1957</u>		25. DATE REC'D. BY LOCAL REG. <u>4-1957</u>	
26. REGISTRAR'S SIGNATURE <u>Clayton W. Landrum</u>			

MAR 12 1951

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 *Forest Gieckhof*.....  
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Licensed Embalmer No. ....

P. O. Address *Hingham*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.