

FILED MAR 25 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7628

STATE FILE NUMBER

296

Registration District No. 42 Primary Registration District No. 1000 Registrar's No.

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1006 So. 15th St.			Length of stay in lb 8 yrs		d. STREET ADDRESS 1006 So. 15th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CALLIE Middle D. Last BARRETT				4. DATE OF DEATH Month Mar Day 15 Year 1957					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 23, 1877		9. AGE (In years last birthday) 79 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Montgomery County Miss.			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James C. Bryant				14. MOTHER'S MAIDEN NAME Mary Loving					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Katie Simmons Address St. Joseph, Mo.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Thrombosis DUE TO (c) Malignant Hypertension								INTERVAL BETWEEN ONSET AND DEATH Several hours 48 hours several yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332X								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. Month, Day, Year 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 Dec. 17, 1955 to Mar. 15, 1957 and last saw <del>him</del> alive on Mar. 14, 1957 Death occurred at 11:15 AM m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Wm. R. Titcomb, D.O.				22b. ADDRESS 1105 N. 26th St. Joseph, Mo.			22c. DATE SIGNED 3-16-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-18-57		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph Missouri			
24. FUNERAL DIRECTOR Stoney Funeral Home				ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. March 20, 1957		26. REGISTRAR'S SIGNATURE Catherine M. Allison	

Health, Welfare  
Public  
Service

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. No standard nomenclature in item 18. 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

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed: *George A. Kerby* .....

Licensed Embalmer No. *476*

P. O. Address *Joseph*

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.