

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20420
STATE FILE NUMBER

FILED JUL 15 1957

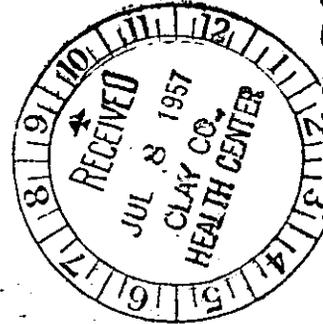
Registration District No. 72 Primary Registration District No. 5289 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY <u>Clay</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Claycomo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Claycomo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>468 E Park ave</u>		Length of stay in 1b <u>27 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>468 E Park ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jasper</u> Middle <u>Newton</u> Last <u>Barr</u>			4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1957</u>		
5. SEX <u>male</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>July 17 1872</u>		9. AGE (In years last birthday) <u>84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Rebin, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13. FATHER'S NAME <u>Francis Marion Barr</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Snell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs. Phillip Davis Harrisonville Mo</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>Cerebral Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Cerebral Arteriosclerosis</u>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>					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 <u>3:30</u> Month <u>June</u> Day <u>27</u> Year <u>1957</u>					
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>June 1953</u> to <u>June 27, 1957</u> and last saw her alive on <u>June 23, 1957</u> . Death occurred at <u>5:30 p.m.</u> on the date stated above; and to the best of my knowledge from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John B Withrow M.D.</u>			22b. ADDRESS <u>2130. S. Mall Antioch Center Kansas City Mo.</u>		22c. DATE SIGNED <u>July 1, 1957</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>July 1-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reclining Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Reclining, Mo</u>
24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons N.K.C.</u>		25. DATE RECD. BY LOCAL REG. <u>7-1-57</u>		26. REGISTRAR'S SIGNATURE <u>Marquitta Judgen</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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This form must be casually related. Coroner cannot certify to a death due to natural causes.



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..... *John Walsbeck*
Licensed Embalmer No. *49*
P. O. Address *Mo. Kansas*

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.