

FILED NOV 20 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40742  
STATE FILE NUMBER

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 100

V. S. 300  
ev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Grandview</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City 34<sup>5</sup></b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Grandview Restorium</b>		Length of stay in lb <b>1 month</b>	d. STREET ADDRESS (If outside, give location) <b>609 Greenway Terr</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>PERRY</b> Last <b>BARNETT</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>15</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 29, 1857</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Court Reporter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Circuit Court</b>	9. AGE (In years last birthday) <b>100</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>Keokuk Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>1</b>	
13a. FATHER'S NAME <b>Frank Barnett</b>		13b. MOTHER'S MAIDEN NAME <b>Naoma Barrett</b>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Raymond Barnett</b> Address <b>609 Greenway Terr</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Pneumonia - Virus</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) <b>492X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 days</b>
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. _____ p.m. Month, Day, Year _____	
20d. INJURY OCCURRED WHILE AT <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 <b>Nov 13-57</b> to <b>Nov 15-57</b> and last saw <b>him</b> live on <b>Nov 14, 1957</b> Death occurred at _____ A _____ M on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Sam A. Hooper, M.D.</b> (Degree or title)		22b. ADDRESS <b>Grandview, Mo.</b>	
22c. DATE SIGNED <b>Nov 15-57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <b>11-18-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Crematory</b>	
23d. LOCATION (City, town, or county) - <b>Kansas City, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Freeman Mortuary</b> ADDRESS <b>K. C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11/15/57</b>	
26. REGISTRAR'S SIGNATURE <b>Delving E. Goodrich</b>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

