

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014787
STATE FILE NUMBER

FILED APR 22 1958

Registration District No. 467 Primary Registration District No. 5606 Registrar's No. 22

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1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Miller</u> c. CITY OR TOWN <u>BRUMLEY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RURAL</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	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>2 1/2 mi. N-E-Pittsville</u>		Length of stay in lb <u>7 days</u>	d. STREET ADDRESS (If outside, give location) <u>3/4 mi. S.-BRUMLEY</u>
			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Dollie</u> Middle <u>JANE</u> Last <u>BARNES</u>			4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1958</u>	
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 July 1896</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At-Home</u>	11. BIRTHPLACE (City and state or country) <u>Hatfield Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Mathis</u>	13b. MOTHER'S MAIDEN NAME <u>MAY Hodck</u>	14. NAME OF HUSBAND OR WIFE <u>John BARNES</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Veolia Pope - Holden-Mo</u>	Address <u>Mo</u>
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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>Hypostatic Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>2 wks</u> <u>4 wks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Blood fastness</u>	
	DUE TO (c) <u>Carcinoma - Stomach 151X</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>NONE</u>
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20c. TIME OF INJURY Hour <u>NONE</u> 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.) <u>NONE</u>	20f. CITY, TOWN, OR LOCATION <u>NONE</u>	COUNTY	STATE
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21. I attended the deceased from <u>4-12-58</u> to <u>4-14</u> and last saw <u>her</u> alive on <u>4-14-58</u> Death occurred at <u>4-17-58-5:55 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>L. Myers D.O.</u>	(Degree or title)	22b. ADDRESS <u>Welland Mo</u>	22c. DATE SIGNED <u>4-17-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>19 April 58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Robnett</u>	23d. LOCATION (City, town, or county) (State) <u>Miller Co. Mo</u>
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24. FUNERAL DIRECTOR <u>Keith M. Page</u>	ADDRESS <u>ELDON Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4-19-58</u>	26. REGISTRAR'S SIGNATURE <u>Mrs G. V. Redford</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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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 *Keith M. Keys*

Licensed Embalmer No. *3998*

P. O. Address *Eldon Mo.*

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.