

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006123

STATE FILE NUMBER

FILED FEB 24 1959

Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 30

2
300
1-57

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Webb City, Missouri		c. CITY OR TOWN Webb City, Missouri	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 210 N. Penn St.		d. STREET ADDRESS (If outside, give location) 210 N. Penn	
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Barnes		4. DATE OF DEATH Month Feb. Day 16, Year 1959	
5. SEX Male	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 Feb. 16, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Cobbler		10b. KIND OF BUSINESS OR INDUSTRY Shoe Shop	11. BIRTHPLACE (City and state or country) Troy Missouri
13a. FATHER'S NAME Willis H. Barnes		13b. MOTHER'S MAIDEN NAME Amanda Reece	14. NAME OF HUSBAND OR WIFE Unknown
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.	17. INFORMANT Mr. R.L. Barnes
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			INTERVAL BETWEEN ONSET AND DEATH 3 days 6 months
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. _____			
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 Feb 9, 1959 to Feb 16, 1959 and last saw ^{her} him alive on Feb 16, 1959 Death occurred at 4:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE P.B. Munson, D.O.		22b. ADDRESS Webb City, Missouri	
		22c. DATE SIGNED 2/17/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2/17/59	
23c. NAME OF CEMETERY OR CREMATORY Hutchinson Cemetery		23d. LOCATION (City, town, or county) (State) Hutchinson Kansas	
24. FUNERAL DIRECTOR Johnston-Arnee-Simpson Mortuary		25. DATE RECD. BY LOCAL REG. 2-17-59	
ADDRESS Webb City, Missouri		26. REGISTRAR'S SIGNATURE Mr. Madeline Switzer	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

P. B. Munson-D.O.

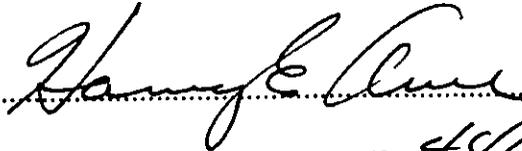
All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

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



Licensed Embalmer No. 4463

P. O. Address. West City

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.