

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022035

STATE FILE NUMBER

FILED JUN 16 1959 Registration District No. 171 Primary Registration District No. 4268 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>												
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mayview</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Mayview</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>The home</b>			Length of stay in lb <b>10 yrs</b>		d. STREET ADDRESS <b>6---</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Mae</b> Last <b>Barker</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1959</b>												
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-16-1890</b>		9. AGE (In years last birthday) <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (City and state or country) <b>Johnson County, Mo.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles T. Ring</b>						14. MOTHER'S MAIDEN NAME <b>Nannie Stovall</b>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----				16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Emmett Barker</b> Address <b>Mayview, Mo.</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 thrombosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>15 hrs 15 min</b>						
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <b>arteriosclerotic heart disease</b>						
										DUE TO (c) <b>4260</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) Diabetes mellitus 2) Cong Heart failure</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 Month, Day, Year 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 <b>1-10-59</b> to <b>6-4-59</b> and last saw her <sup>alive</sup> on <b>6-4-59</b> Death occurred at <b>3:15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.																
22a. SIGNATURE <b>Leif L. Watson, M.D.</b> (Degree or title)										22b. ADDRESS <b>Odessa, Mo.</b>			22c. DATE SIGNED <b>6-5-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>6-7-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Barker Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Lafayette County, Mo.</b>								
24. FUNERAL DIRECTOR <b>Ralph O. Jones, Odessa, Mo.</b> ADDRESS					25. DATE RECD. BY LOCAL REG. <b>6-5-1959</b>			26. REGISTRAR'S SIGNATURE <b>Emma Davidson</b>								

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare public service  
300 1-56 40  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Coroner must use only standard nomenclature in item 18. No symptoms will be listed. Diseases in Part I must be casually 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 embalmed  
by me, or by ....., Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Ralph O Jones*  
Licensed Embalmer No. *46*

P. O. Address *Odessa*

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.