

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036067

FILED VS NOV 1 0 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4887 STATE FILE NUMBER

UNRECORDED

W. W. Newcomer's Sons
 K. C. Mo.
 10-26-59
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF Disposition
 W. W. Newcomer's Sons
 K. C. Mo.

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BUCHANAN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN ST. JOSEPH	
Length of stay in lb 30 DAYS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3927 BELL		d. STREET ADDRESS (If outside, give location) 826 PARKER	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETHEL ELSIE BARNETT			4. DATE OF DEATH Month OCT Day 9 Year 1959
5. SEX FEMALE	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 JAN 7 1887
9. AGE (last birthday) 72yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY WINDFORD SOUTH DA.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME ELIJAH HINES		13b. MOTHER'S MAIDEN NAME ALTA DINGMAN	14. NAME OF HUSBAND OR WIFE Walter K. Barnett SID MARVIN BARNETT
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. 491 09 3170	17. INFORMANT NELLI E. WIDMAR 3927 BELL ST. K. C. MO.
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 VASCULAR ACCIDENT			INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) GENERALIZED ARTERIOSCLEROSIS			OVER 10 YRS
DUE TO (c) DECOMPENSATING HEART			OVER 10 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) MYOCARDIAL INSUFFICIENCY			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 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>9-5-1959</u> to <u>10-9-1959</u> and last saw her/him alive on <u>9-29-1959</u> Death occurred at <u>about 8:10 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Myron R. D. D.O.</i>		22b. ADDRESS 3504 Trask Ave. K.C. Mo	22c. DATE SIGNED 10-9-59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE OCT 2, 1959	23c. NAME OF CEMETERY OR CREMATORY MT. AUBURN, CEM
23d. LOCATION (City, town, or county) (State) ST. JOSEPH MO.		24. FUNERAL DIRECTOR ADDRESS D. W. NEWCOMER'S SONS K. C. MO.	
25. DATE RECD. BY LOCAL REG. 10-12-59		26. REGISTRAR'S SIGNATURE <i>Preva Marshall</i>	

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 Albert L. Navage, H.S.

Licensed Embalmer No. Hanson

P. O. Address _____

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.