

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014223

FILED VS MAY 2 1960

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Buchanan				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 St. Joseph		Length of stay in 1b		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 411 E. Missouri Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Lola Middle Leona Last Barnett				4. DATE OF DEATH Month April Day 24 Year 1960									
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 March 22, 1891		9. AGE (last birthday) 69		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (City and state or country) Dell Rapids, South Dak.		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME Henry E. Henderson				13b. MOTHER'S MAIDEN NAME Cora Mass				14. NAME OF HUSBAND OR WIFE A. C. 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. None		17. INFORMANT (son) Harold Sommers St. Joseph Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Carbon monoxide poisoning (suicide)										2 days			
DUE TO (b) agitated depression										month			
DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease (condition given in PART I (a)) overdose of sedative (barbital)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 _____ 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 11/5/59 to 4/24/60 and last saw her ^{her} him alive on 4/23/60		Death occurred at 9:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE Donald J. Stallard, M.D. (Degree or title)				22b. ADDRESS 902 Edmund St.				22c. DATE SIGNED 4/26/60					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 26, 1960		23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery				23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri					
24. FUNERAL DIRECTOR Thierhoff-Edmonds ADDRESS St. Joseph Mo.				25. DATE RECD. BY LOCAL REG. April 27, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell							

DOCUMENT

D. J. Stallard, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

0961 8214571

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Don J. Chasney

Licensed Embalmer No. 4679

P. O. Address 5705

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.