

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-034623**

**FILED VS OCT 3 1960**

**4746**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>                |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Length of stay in lb OR TOWN <u>30 Yrs</u>  |  | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hosp</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location) <u>6600 E 16 St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |

|  |                               |   |   |                                  |                                |
|--|-------------------------------|---|---|----------------------------------|--------------------------------|
| 3. NAME OF DECEASED (Type or print)<br><u>George T. Barber</u> First Middle Last |                               |   | 4. DATE OF DEATH<br><u>9 18 60</u> Month Day Year |                                  |                                |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/8/19 81</u>                 | 9. AGE (last birthday) <u>81</u> | IF UNDER 1 YEAR IF UNDER 24 HR |

|  |   |   |   |
|--|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>         | 10b. KIND OF BUSINESS OR INDUSTRY <u>Burlington P. Paper Co</u> | 11. BIRTH PLACE (City and state or country) <u>Mo. U.S.A.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Doc Barber</u>   | 13b. MOTHER'S MAIDEN NAME <u>MARY JANE SHARITZER</u>            | 14. NAME OF HUSBAND OR WIFE <u>Florence Barber</u>            |   |
| 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>?</u>                                | 17. INFORMANT <u>Florence Barber 6606 E 16 St</u> Address     |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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>9-17-1960</u> to <u>9-18-60</u> and last saw him alive on <u>9-18-1960</u><br>Death occurred at <u>2:05 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |

|  |   |  |
|--|---|--|
| 22a. SIGNATURE (Degree or title) <u>H. L. Dwyer M.D.</u> | 22b. ADDRESS <u>2400 Cherry St</u>          | 22c. DATE SIGNED <u>9/20/60</u>                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE <u>9-20-60</u>                    | 23c. NAME OF CEMETERY OR CREMATORY <u>Lathrop Cem.</u> |
| 24. FUNERAL DIRECTOR <u>Sheil Funeral Home K.P. Mu</u>   | 25. DATE RECD. BY LOCAL REG. <u>9-19-60</u> | 26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>           |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. L. Dwyer

**STATEMENT BY LICENSED EMBALMER**

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 \_\_\_\_\_

Licensed Embalmer No. 4954

P. O. Address J.C.M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.