

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

9869 - 62-039970  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. <del>FILED</del> <b>OCT 19 1962</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
a. COUNTY			a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b <b>5mo.</b>	c. CITY OR TOWN <b>Kansas City</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>Masonic Home Of Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>101 East 36th Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Barnhisel</b>			4. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>1962</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/17/1876</b>	9. AGE (last birthday) <b>86</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	11. BIRTHPLACE (City and state or country) <b>Lawrence, Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Barnhisel</b>		13b. MOTHER'S MAIDEN NAME <b>Laura Alice Bruce</b>		14. NAME OF HUSBAND OR WIFE <b>Mabel M. Mc Grown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Masonic Home of Missouri</b> <b>5351 Delmar Blvd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b>					<b>1 hr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <b>Generalized arteriosclerosis</b>					<b>unknown</b>
DUE TO (c) <b>4201</b>					
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. <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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>6-10-62</b> to <b>10-12-62</b> and last saw her/him alive on <b>10-12-62</b> Death occurred at <b>2:40</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Harold E. Walters, M.D.</b> (Degree or title)			22b. ADDRESS <b>3720 Washington St. hoi.</b>		22c. DATE SIGNED <b>10-13-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-15-62</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR <b>Earp &amp; Sons Funeral Home, Kansas City, Mo.</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>OCT 15 1962</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

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**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 Stanley F. Arison

Licensed Embalmer No. 4193

P. O. Address J. R.

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.