

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=63-019820**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 107

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED MAY 27 1963</b>		1. PLACE OF DEATH a. COUNTY <u>GRUNDY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>GRUNDY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>TRENTON</u>		Length of stay in 1b		c. CITY OR TOWN <u>TRENTON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME 410 EAST 11TH</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>410 EAST 11TH ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LUCK</u> Middle <u>MAY</u> Last <u>BARNES</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>1963</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-1881</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>MERCER CO. MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>JOHN W. THOGMARTIN</u>		13b. MOTHER'S MAIDEN NAME <u>MELISSA ARABELLE KELSO</u>	
14. NAME OF HUSBAND OR WIFE <u>THOMAS WALTER BARNES</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>[REDACTED]</u>	
17. INFORMANT <u>EARL BARNES TRENTON MO. RI</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Renal Disease</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-Sclerosis</u> DUE TO (c) _____  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		INTERVAL BETWEEN ONSET AND DEATH	
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>Jan 26-1963</u> to <u>May 16, 1963</u> and last saw her/him alive on <u>May 15-1963</u> Death occurred at <u>12:05</u> p. m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>[Signature] M.D.</u>			22b. ADDRESS <u>Trenton, Mo.</u>		22c. DATE SIGNED <u>May 18-1963</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-18-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEMETERY</u>		23d. LOCATION (City, town, or county) <u>SPICKARD MO.</u>	
24. FUNERAL DIRECTOR <u>WISE FUNERAL HOME</u>		ADDRESS <u>SPICKARD MO.</u>		25. DATE RECD. BY LOCAL REG. <u>5-18-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FORM 10-1957

10000  
10000

**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 Cross Wise

Licensed Embalmer No. 3771

P. O. Address Spickard Mo.

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.