

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046961
STATE FILE NUMBER

Registration District No. 17 Primary Registration District No. 3005 Registrar's No. 206

FILED DEC 23 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
Rev. 4/59						
1 <u>0071</u>						
2 <u>0190</u>						
3 <u>2</u>						
4 <u>1</u>						
5 <u>2</u>						
6						
7 <u>0</u>						
8 <u>0</u>						
<u>9334X</u>						
10						
11						
12 <u>1-0</u>						
13 <u>1-0</u>						
ITEM NO.	SHOULD READ					

1. PLACE OF DEATH a. COUNTY <u>Bates</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Butler, Mo.</u>		Length of stay in lb <u>7 days</u>	c. CITY OR TOWN <u>Archie</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bates County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5 Miles East</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>May</u> Last <u>Barnard</u>			4. DATE OF DEATH Month <u>December</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>1/28/1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (last birthday) <u>89</u> IF UNDER 1 YEAR: Months <u>10</u> Days <u>18</u> IF UNDER 24 HR: Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Foster, Bates Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John Demott</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Foster</u>	
14. NAME OF HUSBAND OR WIFE <u>J. Arthur Barnard, Dec.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>[Redacted]</u>		17. INFORMANT Address <u>Mr. John Barnard Archie, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Bronchopneumonia</u> DUE TO (b) <u>Cerebral and Generalized Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease: <u>Arteriosclerosis, Hypertension, Hypertrophic Cardiomyopathy, Anemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>10 yrs.</u>
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 <u></u> a.m. <u></u> p.m. <u></u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from <u>May 2-1960</u> to <u>Dec 16, 1963</u> and last saw her alive on <u>Dec 15, 1963</u> Death occurred at <u>9:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Carter W. Luster M.D.</u>		22b. ADDRESS <u>Butler Mo</u>	
22c. DATE SIGNED <u>12/18/63</u>		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/19/1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Crescent Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Adrian, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Atkinson-Dickey Archie, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-18-1963</u>	
26. REGISTRAR'S SIGNATURE <u>Norman J. Wilson</u>			

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 *Robert W. Atkinson*

Licensed Embalmer No. 4902

P. O. Address *Spencer, 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.

Permit returned - 12-18-53