

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____		REG. DIST. NO. 319		PRIMARY REG. DIST. NO. 6080		Registrar's No. 48	
1. PLACE OF DEATH a. COUNTY Ste Genevieve				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before death) a. STATE Missouri b. COUNTY Ste Genevieve			
b. CITY OR TOWN rural (Saline)		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN rural		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 2950	
d. FULL NAME OF HOSPITAL OR INSTITUTION				e. STREET ADDRESS (If rural, give location) near Coffman Missouri			
3. NAME OF DECEASED (Type or Print) a. (First) WALTER		b. (Middle) BARRON		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Aug 29 1954	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH May 28 1888	
9. AGE (In years) (App. birthday) 66		IF UNDER 1 YEAR Months Days		IF UNDER 1 HR. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Mine la Motte Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Isaac Barron		13b. MOTHER'S MAIDEN NAME Elizabeth Crahree		14. NAME OF HUSBAND OR WIFE Jennie Barron			
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. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Glen Barron Farmington Missouri			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4200				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 29			
22. I hereby certify that I attended the deceased from 423 , 1954, to 8-28 , 1954, that I last saw the deceased alive on 8-25 , 1954, and that death occurred at 1 A m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) C. H. Appleberry M.D.				23b. ADDRESS Flour River Mo		23c. DATE SIGNED 8-30-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug 31 1954		24c. NAME OF CEMETERY OR CREMATORY Mayberry		24d. LOCATION (City, town, or county) (State) Coffman Missouri	
DATE REC'D BY LOCAL REG. Sept 1 1954		REGISTRAR'S SIGNATURE Louella Basler		25. FUNERAL DIRECTOR'S SIGNATURE Cozean Farmington Missouri		ADDRESS	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SER 84 1954

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..... *W. Cozart*

Licensed Embalmer No. *408*

P. O. Address *Farmington*

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.