MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Jasper

Township Joplin

or

Village

or

City Webb City (NO. 7th & Liberty St.; Ward)

Registration District No. 417 File No. 29702

Primary Registration District No. 3021 Registered No. 187

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ben Harrison Barnes

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Aug. 13, 1888 (Month) (Day) (Year)

AGE 30 yrs. 1 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Kansas

PARENTS

NAME OF FATHER G. M. Barnes

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill

MAIDEN NAME OF MOTHER Liddy Blankinship

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kem

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. G. C. Barnes

(ADDRESS) Webb City Mo.

Filed Sept. 19th 1918 C. E. McBride REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 18, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 5, 1918, to Sept 18, 1918, that I last saw him alive on " 17, 1918, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

108 92

(Duration) ___ yrs. ___ mos. 18 ds.

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) O. W. Barsour M. D.

Sept 18, 1918 (Address) Oronogo Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Webb City Cem

DATE OF BURIAL Sept 20 1918

UNDERTAKER Webb City Und Co

ADDRESS Webb City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. .... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....;

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory
(SECONDARY) .....

.....(Duration).....yrs. .....mos. .....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS