

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

Do not use this space.

29613

**1. PLACE OF DEATH**

County Buchanan  
Township .....  
City St. Joseph, (No. 3323 Scott Street)

Registration District No. 85  
Primary Registration District No. 1001

File No. ....  
Registered No. 1070  
St. .... Ward)

**2. FULL NAME**

Edward Francis Barnes

(a) Residence. No. 3323 Scott Street St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 24 da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May. 24. 1927.

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>0</u>	<u>4</u>	<u>24</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Child  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) St. Joseph, (STATE OR COUNTRY) Missouri.

PARENTS

10. NAME OF FATHER George J Barnes  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wright County, (STATE OR COUNTRY) Missouri.  
12. MAIDEN NAME OF MOTHER Minnie Trapp  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Joseph, (STATE OR COUNTRY) Missouri.

14. INFORMANT George J Barnes (Address) 3323 Scott Street

15. FILED 10/21 1927 G. J. Barnes REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) October. 18 1927.

17. I HEREBY CERTIFY, That Edward deceased from ca Oct 19, 1927, to ..... 19..... that I last saw him in alive on ..... 19..... and that death occurred, on the date stated above, at ..... 3 p.m. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Bronchial Pneumonia  
1070/1001 (duration) ..... yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY) Unknown (duration) ..... yrs. .... mos. .... da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Specimen & Previous  
Diagnosis of tuberculous meningitis  
(Signed) W. H. Myers M. D.  
Oct. 19 27 (Address) St. Joseph Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Mount Olivet Cemetery Oct. 20. 1927.  
20. UNDERTAKER ADDRESS

H. C. Sinden 1802 Union Str.

Every name or abbreviation 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.

