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

Do not use this space.

33695

File No. 1
Registered No. 4/2 D

1. PLACE OF DEATH

County: Jackson — Registration District No. 399
Township: Kaw — Primary Registration District No. 1002
City: Kansas City (No. 2819 Harrison St. Ward)

2. FULL NAME Margret Dean Barnes

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Fe	white	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 6 - 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	71	5	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky -

PARENTS

10. NAME OF FATHER John Taylor
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky -
12. MAIDEN NAME OF MOTHER Eliz. Patton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky -

14. INFORMANT Mrs. J. H. Flannery
(Address) 2819 Harrison

15. FILED 10/18, 1928 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 16 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1928, to Oct 16 1928, that I last saw her alive on Oct 16 1928 and that death occurred, on the date stated above, at 10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic
myocarditis
43C
11V (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Asthma (duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

10/16, 1928 (Signed) C. L. Martin M. D.
(Address) 310 Chambers Bldg

*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
Mt. Hope	Oct 19 1928
20. UNDERTAKER	**ADDRESS**
Mrs. C. L. Forster	K.C. Mo.

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.

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