

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

Do not use this space.

13268

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

File No.....

Towship.....

Primary Registration District No.....

3003

Registered No.....

3854

City.....

(No. *City Hospital # 2*)

St. .... Ward)

**2. FULL NAME**

*Susie Barnes*

(a) Residence. No. *2160 Farrar St.* St. *26* Ward. ....  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *54* yrs. *0* mos. *14* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *8/14/1874*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*54 7 24*

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

10. NAME OF FATHER *Abe Barnes*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

12. MAIDEN NAME OF MOTHER *Rachael Barber*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

14. INFORMANT (Address) *Destella Beston City Hospital #2*

15. FILED *1929* REGISTRAR *Karl C. Taylor*

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-28-1929*

17. I HEREBY CERTIFY, That I attended deceased from *3-14-1929* to *3-28-1929* that I last saw him alive on *3-28-1929* and that death occurred, on the date stated above, at *9:05 A.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Cerebral apoplexy 131*  
*High Blood Pressure 102*  
(duration) yrs. mos. *16* ds.

CONTRIBUTORY (SECONDARY) *Chronic nephritis*  
(duration) yrs. mos. *9* ds.

18. WHERE WAS DISEASE CONTRACTED *124 W*  
IF NOT AT PLACE OF DEATH

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

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Toh & clinical*  
(Signed) *Th. Cunningham, M.D.*  
, 19 (Address) *2945 Newton*

\*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 *Friends Cem* DATE OF BURIAL *3-30-1929*

20. UNDERTAKER *E. Scott, 3015 Taylor av*  
ADDRESS

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 FADING INK—THIS IS PERMANENT RECORD

235  
1  
31  
31

