

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

Do not use this space.

42416

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City..... (No. *Missouri Baptist Hospital* St. Ward)

File No.
 Registered No. **12145**

2. FULL NAME

Rev. Wm H Barnes
 (a) Residence. No. **4942 Phologan** St., **16** Ward. **4942 Phologan**
 (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 *Male* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)** *Married*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF *Mary L. Barnes*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept. 7 1849*
7. AGE YEARS *80* MONTHS *3* DAYS *5* If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Minister of the Gospel*
 (b) General nature of industry, business, or establishment in which employed (or employer) *Retired*
 (c) Name of employer

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

10. NAME OF FATHER *Diphno Barnes*

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

12. MAIDEN NAME OF MOTHER *Sarah Johnson*

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

14. INFORMANT *Mrs. F. P. White*
 (Address) *4942 Phologan av.*

15. FILED *13 1929* *Wm C Starnes* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec. 12th 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Nov 2*
1929, to *Dec 12* *1929*
 that I last saw him *live on Dec 12 1929*, and that death occurred, on the date stated above, at *10³⁰ a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sudden Remission of Arterio Sclerosis *103*

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Old age*
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *at home*

IF NOT AT PLACE OF DEATH

AND OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. S. M. Smith*, M. D.

2/13/1929 (Address) *720 1/2 Center 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 *See Fee Cemetery* **DATE OF BURIAL** *Dec 14 1929*

20. UNDERTAKER *Philander Craig Washington* **ADDRESS** *446*

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.

2 1929

