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

Do not use this space.

17472

File No. 2

Registered No. 8

1. PLACE OF DEATH

County: Mus

Registration District No. 1051

Township: James Bayou

Primary Registration District No. 5768

City: Dorsey (No. ..... St. ..... Ward)

2. FULL NAME: William Franklin 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.

JUN 23 1934

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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 9 - 1853

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	80	5	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(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): Ky

PARENTS

10. NAME OF FATHER: Joseph Barnes

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

12. MAIDEN NAME OF MOTHER: Carlina Baker

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

14. INFORMANT: Mrs. Nate Edmonds

(Address): Hickman Ky.

15. FILED 5-23 1934 J. E. Burk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): 5 - 22 1934

17. I HEREBY CERTIFY, That I attended deceased from 5-20, 1934, to 5-22, 1934, that I last saw him alive on 5-20, 1934, and that death occurred, on the date stated above, at 2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Organic Heart disease

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): General debility (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. L. Baker, M. D.

, 19 (Address) Hickman Ky.

*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
Brownville Ky.	5-23-1934
20. UNDERTAKER	**ADDRESS**
Barrett & Stokes	Hickman Ky.

#2

Mississippi

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

17472

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.
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Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Wm Franklin Barnes
Who died at _____ on May 22 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex M Color or race W ~~Single~~, married, ~~widowed or divorced~~: _____

Date of birth _____ Age: Years 80 Months 5 Days 14

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) Organic heart disease
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: Gen Debility
endocarditis Chronic

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____
Signature of Registrar, J. E. Deitle, 5-22-1934
Date filed

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 1051

Primary Reg. Dist. No. 5768

Very truly yours,
E. T. McGaugh M.D.
Special Agent.

S-17472