

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.

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

Do not use this space.

DEC 17 1935

35346

1. PLACE OF DEATH

County Callaway
Township _____
City Fulton (No. _____)

Registration District No. 104
Primary Registration District No. 3008

File No. _____
Registered No. 236
St. _____ Ward _____

2. FULL NAME David B. Barnes

(a) Residence, No. State Hospital 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. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Wm's Dr. Barnes</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>OK - July 6 - 1866</u>		
7. AGE YEARS <u>73</u>	MONTHS <u>4</u>	DAYS <u>9</u>
If LESS than 1 day,hrs. ormin.		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>farmer</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
11. Total time (years) spent in this occupation		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>OK. Mo</u>		
13. NAME <u>Wm Barnes</u> <u>OK.</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>OK Pa</u>		
15. MAIDEN NAME <u>Margt Dr. Hill</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>OK. Pa</u>		
17. INFORMANT <u>Records</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>MT Olivet Mo</u> DATE <u>Nov 16</u> 19 <u>35</u>		
19. UNDERTAKER <u>Wm. Kates</u> (ADDRESS) <u>Wm. Kates, Mo</u>		
20. FILED <u>Nov 18, 1935</u> <u>A. N. Crews</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11 - 15 1935

22. I HEREBY CERTIFY, That I attended deceased from 11 - 12 1935 to 11 - 15 1935

I last saw him alive on 11 - 14 1935 Death is said to have occurred on the date stated above, at 12:44 A. M.

The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia Date of onset 11-13-35

Other contributory causes of importance:
Chronic hepatitis
Myocardial deficiency.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. 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 _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) Richard B. Bradshaw, M. D.
(Address) Fulton, Mo.

