

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10987
Registrar's No. 285

FILED APR 1 1940

Registration District No. _____

Primary Registration District No. 2001

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day / 1
(Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME John M. Barnes 6572

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ola Barnes

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 10 1883
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Christian County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Merchant

11. Industry or business General Merchantile

12. Name William E. Barnes

13. Birthplace Searcey County Arkansas
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Farmer

15. Birthplace Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Ola Barnes

(b) Address Route # 7 Springfield, Mo.

17. (a) Burial (b) Date thereof March 21 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo. 2001

19. (a) 3/21/40 (b) Chas. A. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. Route # 7
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20 year 1940 hour 3 minute 2 M.

21. I hereby certify that I attended the deceased from Mar 19, 1940, to Mar 20, 1940.
that I last saw him alive on Mar 20, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 3 day

Due to Coronary Sclerosis ?

Due to _____

Other conditions 4418
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Coronary Occlusion

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature F. B. Gump (M. D. or other) 1

Address Springfield Date signed 4-20-40

PHYSICIAN
Underline the cause to which death should be charged statistically

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Walter E. Hamelton

Licensed Embalmer No. *3808*

P. O. Address *Springfield, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

X