

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED SEP 5 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27488

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3121

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Jackson
(c) Name of hospital or institution: 514 1/2 main st
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community Underwood
years, months or days)

3. (a) PRINT FULL NAME A. Barnes 652
(b) If veteran, name war (A. Barnes)
(c) Social Security No. 20

4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced single
6. (c) Age of husband or wife if all Unknown years
7. Birth date of deceased 1890
(Month) (Day) (Year)

8. AGE: 50
Years Months Days If less than one day
hr. min.

9. Birthplace MO (City, town, or county) (State or foreign country)

10. Usual occupation Luban

11. Industry or business Unknown

MOTHER FATHER
12. Name DO Unknown
13. Birthplace (City, town, or county) Unknown (State or foreign country)
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Coroner's Office
(b) Address Kansas City, Missouri

17. (a) Removed (b) Date thereof Aug 5 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrence, Mo

18. (a) Signature of funeral director Perry
(b) Address Kansas City, Mo.

19. (a) Aug. 5, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Jackson
(c) City or town Kansas
(If outside city or town limits, write "RURAL")
(d) Street No. 514 1/2 main
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 31
year 1940 hour 10 minute P. M.

21. I hereby certify that I examined the deceased from
to
that I temporarily all on
and that death occurred on the date and hour stated above.
Immediate cause of death

Due to Chronic myocarditis 92.0

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Impaction
PHYSICIAN Underline the cause to which death should be charged statistically.

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 5

23. Signature M. M. Crowe (M. D. or other)
Address Date signed

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 Parla Rowe

Licensed Embalmer No. 2347

P. O. Address 12 Cmo

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, fact should be so stated above.