

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14263**
Registrar's No. **38**

Registration District No. **4194**

Primary Registration District No. **4194**

1. PLACE OF DEATH:

(a) County **Gentry**
(b) City or town **Albany**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community **All her life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Carolyn Eva Barnes**

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Orva Barnes** 6. (c) Age of husband or wife if alive **46** years
7. Birth date of deceased **January 26 1897**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 2 21 hr. **5** min.

9. Birthplace **Allendale Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business

12. Name **J. P. Weddle**
13. Birthplace **Harrison Co. Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Olive Roach**
15. Birthplace **Allendale Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Orva Barnes**
(b) Address **Albany, Mo.**
17. (a) **Burial** (b) Date thereof **4/18/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Grandview**

18. (a) Signature of funeral director **Clifford Burke**
(b) Address **Albany, Mo.**
19. (a) **April 17-1943** (b) **Samuel M. Miller**
(Date received local registrar) (Registry signature)
Wm. H. Miller (Licensed Embalmer)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Gentry**
(c) City or town **Albany**
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **16**
year **1943** hour **11** minute **10P.** M.
21. I hereby certify that I attended the deceased from **Jan. 22-43**
to **April 16 1943**
that I last saw her alive on **April 16 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocarditis** Duration **4 yrs.**

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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
23. Signature **Frank H. Rose** (M. D. or other) **M. D.**
Address **Albany, Mo.** Date signed **4-17-43**

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

MAR 27 1947

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Chas. H. Brown
Licensed Embalmer No. 3329

P. O. Address.....

Albany 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, fact should be so stated above.