

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34175

Registrar's No. 1209

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1307 North 11th. Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Not
In this community 87 years 7 months 6 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1307 North 11th. Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ()

3. (a) PRINT FULL NAME Sarah Angeline Karnes

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased February 26 1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 7 6 hr. min.

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

10. Usual occupation Home

11. Industry or business _____

12. Name James G. Karnes

13. Birthplace Unknown Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Nancy H. Peters

15. Birthplace Monroe County Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Kate V. Karnes

(b) Address 1307 No. 11th. St. Joseph, Mo.

17. (a) Burial (b) Date thereof 10/25/1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1302 Faraon St., St. Joseph, Mo.

19. (a) 10-25-43 (b) Rae Henry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22nd,
year 1943 hour 11:40 minute A. M.

21. I hereby certify that I attended the deceased from
10-1, 1943, to 10-15, 1943
that I last saw her alive on 10-15, 1943,
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration Over 1 mo

Due to Arteriosclerosis over 1 yr

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 93d 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) (a) Means of injury _____
23. Signature Walter Meierhoffer (M. D. or other) _____
Address 718 7th St. Joseph, Mo. Date signed 10/25/43

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

MOTHER FATHER

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 *Albert C. Harrington*

Licensed Embalmer No. *3368* *Missouri*

P. O. Address *St. Joseph, Missouri.*

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.