

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5932  
Registrar's No. 554

FILED FEB 18 1944  
Registration District No. 179

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:  
3200 Norledge K.C. 4 Count.  
(If not in hospital or institution, write street number or location)

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

In this community 50 yrs.

3. (a) PRINT FULL NAME MARGARET MABEL BARNHART

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fe. 5. Color or race White

6. (a) Name of husband or wife David B.

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

7. Birth date of deceased unk  
(Month) (Day) (Year)

8. AGE: Years app 68 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Homemaker

11. Industry or business None

MOTHER FATHER

12. Name Mr. Price

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

14. Maiden name Unknown

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

16. (a) Informant Gordon H. Trabue

(b) Address Route 2, Indep. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address Kansas City, Mo.

19. (a) 2-3-1944 (Date received local registrar) (b) T E Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 5037 E. 8th St. 8  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2 year 1944 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from 1-2-44 19. to 2-1-44 19. and that death occurred on the date and hour stated above.

I last saw h. er. alive on 1-31-44 19.

Immediate cause of death Carcinoma of Breast

Due to Ca with Metastases

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

Major findings: Of operations \_\_\_\_\_

Of autopsy 50

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 0

23. Signature [Signature] (M. D. number) \_\_\_\_\_

Address 522 Maple St Date signed 2-5-44

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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.....

Licensed Embalmer No. 3639

P. O. Address..... N. C. 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.**