

V. S. No. 2  
00M-5-43  
Rev. 5-17-39  
I X36871

FILED SEP 1 1945  
149

State File No. \_\_\_\_\_  
Registrar's No. 3401

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002

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:  
4102 Holly /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 55 Years years, months or days)

3. (a) PRINT MRS. ANGIE BARKER  
FULL NAME  
3. (b) If veteran, No name war 3. (c) Social Security None No.

4. Sex Female 5. Color or White race  
6. (a) Single, widowed, married, Married  
divorced  
6. (b) Name of husband or wife William T. Barker 6. (c) Age of husband or wife if 81  
alive years  
7. Birth date of deceased October 27, 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 9 16 hr. min.

9. Birthplace Gallion, Ohio /  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business No Record

MOTHER FATHER

12. Name XXXXXXXXXX  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) 4  
14. Maiden name XXXXXXXXXX  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) 6

16. (a) Informant William T. Barker  
(b) Address 4102 Holly

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director John W. Wagner  
(b) Address Kansas City, Missouri

19. (a) 8-14-45 (Date received local registrar) (b) Sheraldine Thomas (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") 8  
(d) Street No. 4102 Holly (If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13th  
year 1945 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 1, 1945 to Aug 13, 1945  
that I last saw her alive on Aug 13, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions 830  
(Include pregnancy within 3 months of death)

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

Duration  
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 1  
23. Signature Dr. Bertha B. Linger (M. D. or other) DC  
Address 900 E. 57th Terr Date signed 8/14/45

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

Bertner & Livingston, D.C.  
200 East 51st St.  
W.E. 1984

**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..... *Cecil R. Matthes* .....

Licensed Embalmer No. *3807* .....

P. O. Address..... *Kansas City, 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.**