

FILED OCT 29 1945 STANDARD CERTIFICATE OF DEATH

State File No. 32554

Registrar's No. 4239

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH: Jackson

(a) County..... Jackson

(b) City or town..... Kansas City

(c) Name of hospital or institution:  
Northeast Hospital

(d) Length of stay: In hospital or institution..... 1 day

In this community..... 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo (b) County..... Jackson

(c) City or town..... Kansas City

(d) Street No..... 6501 E 10th

(e) Citizen of foreign country?..... no

3. (a) PRINT FULL NAME Sharon Kay Barker

3. (b) If veteran, name war..... no

3. (c) Social Security No..... NO

4. Sex..... Fem / 5. Color or race..... Wh

6. (a) Single, widowed, married, divorced..... S 0

6. (b) Name of husband or wife..... "

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

7. Birth date of deceased..... 10/14/45

8. AGE:	Years	Months	Days	If less than one day
	0	0	1	hr. min.

9. Birthplace..... Kansas City, Mo.

10. Usual occupation..... infant

11. Industry or business.....

12. Name..... Bert Barker

13. Birthplace..... Dinsmore, ark.

14. Maiden name..... Frankie Greer Barker

15. Birthplace..... Jasper, Ark.

16. (a) Informant Bert Barker

(b) Address 6501 E 10th St.

17. (a) Burial (b) Date thereof..... 10/16/45

(c) Place: burial or cremation..... Floral Hills Cem.

18. (a) Signature of funeral director..... John P. Shell

(b) Address..... Kansas City, Mo

19. (a) 10-16-45 (b) Steadman Holmes

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 15

year 1945 hour 1 P M minute P

21. I hereby certify that I attended the deceased from Oct 14 1945 to Oct 15 1945

that I last saw her alive on Oct 15 1945 and that death occurred on the date and hour stated above.

Immediate cause of death..... Asphyxia

..... Acute Myocarditis

Due to..... Non viable fetus with improperly developed organs

Due to..... circulatory & respiratory

Other conditions.....

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?.....

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work..... (Specify type of place)

23. Signature..... (e) Means of injury.....

Address..... Date signed.....

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

18  
3  
8

**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..... *John P. Sheel* .....

Licensed Embalmer No. *3625* .....

P. O. Address..... *R 6 W* .....

**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.**