

FILED DE 22 6 1945

Registration District No. _____ Primary Registration District No. **1000**

Registrar's No. **1234**

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

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: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 week
(Specify whether years, months or days)
 In this community 75 years

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. 1120 Main Street
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mary Leala 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 Widow 2
 6. (b) Name of husband or wife James H. Karnes 6. (c) Age of husband or wife if alive 3 years 1859
 7. Birth date of deceased November (Month) 3 (Day) 1859 (Year)

8. AGE: Years 86 Months 0 Days 11 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name Isaac N. Owens
 13. Birthplace Unknown Maryland
(City, town, or county) (State or foreign country)
 14. Maiden name Amanda K. Farmer
 15. Birthplace Danville Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Virginia Galloway
 (b) Address 2422 Felix St., St. Joseph, Missouri

17. (a) Burial (b) Date thereof 11/16/1945
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director: Walter Meierhoffer
 (b) Address 1302 Farson St., St. Joseph, Missouri

19. (a) Nov 20 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH, Month November day 14th
 year 1945 hour 6 minute 45 A. M.

21. I hereby certify that I attended the deceased from Nov. 6 1945 to Nov. 6 1945
 that I last saw her alive on Nov 6 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia
 Due to: Entered hospital in extremis
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Duration 1 week
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

Major findings: Of operations _____
 Of autopsy 107

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 [Signature] (M. D. or other) _____
 Address St. Joseph, Mo Date signed 11-17-45

RECEIVED

District Health Officer No. 11,

District File Number.....

Date Filed.....

DEC 6 1945

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 P. Harrington*

Licensed Embalmer No. 3258 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.