

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

**FILED** (Stamp)  
Registration District No. **159**

Primary Registration District No. **5848**

Registrar's No. **7**

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

**1. PLACE OF DEATH:**  
 (a) County Nodaway  
 (b) City or town Barnard Rural Grant Twp  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community About 24 yrs.  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Nodaway  
 (c) City or town Barnard  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Mary Almah Barnes  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Nov day 14  
 year 1945 hour 1 minute 55 A.M.  
 21. I hereby certify that I attended the deceased from 11 ch  
1 1945 to Nov - 14 - 1945  
 that I last saw her alive on Nov - 14 - 1945 1945  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Isaac M. Barnes Deceased  
 6. (c) Age of husband or wife if Deceased years  
 7. Birth date of deceased January 6 1861  
(Month) (Day) (Year)

Immediate cause of death arterio sclerosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions arterio sclerosis  
(Include pregnancy within 3 months of death)

**8. AGE:** Years 84 Months 10 Days 8  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace Lewassy Missouri  
(City, town, or county) (State or foreign country)  
 10. Usual occupation House wife

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy 97  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**MOTHER FATHER**  
 11. Industry or business \_\_\_\_\_  
 12. Name William A. Strickland  
 13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary Katherine Wintauer  
 15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

**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? \_\_\_\_\_

16. (a) Informant Sallie J. Capmichael  
 (b) Address Barnard  
 17. (a) Burial (b) Date thereof 11-17-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Larned Kansas  
 18. (a) Signature of funeral director Campbell Funeral Home  
 (b) Address 951 South Main Street  
 19. (a) Nov 17 1945 (b) W. Logan Wood  
(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
 23. Signature W. Logan Wood (M. D. or other) \_\_\_\_\_  
 Address Bolckow, Mo. Date signed 11/14-45

1599

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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..... *Margaret L. Campbell* .....

Licensed Embalmer No. *4292* .....

P. O. Address..... *Maryville, 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.**