

FILED JAN 28 1946

Registration District No. 279

Primary Registration District No. 4415

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Clarksville
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME

James Franklin Barnes

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if:

alive years

7. Birth date of deceased

Nov 18 1962
(Month) (Day) (Year)

8. AGE:

Years 83
Months 81
Days 13

If less than one day

hr. min.

9. Birthplace

Moberly Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation

Retired

11. Industry or business

12. Name

Daniel Barnes

13. Birthplace

Don't know 9
(City, town, or county) (State or foreign country)

14. Maiden name

Whitie

15. Birthplace

Don't know 9
(City, town, or county) (State or foreign country)

16. (a) Informant

Mo. Barnes

(b) Address

Clarksville

17. (a)

Burial (b) Date thereof Jan 2 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

Greenwood

18. (a) Signature of funeral director

Harry L. Carroll

(b) Address

Clarksville Mo.

19. (a)

1-3-46 (b) Luke Richard
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pike 82
(c) City or town Clarksville
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31
year 1945 hour 6 minute P M.

21. I hereby certify that I attended the deceased from Dec 1 1945 to Dec 31 1945
that I last saw him alive on Dec 31 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pernicious Anemia Duration 5 yrs

Due to not know

Due to

Other conditions General Arterio Sclerosis
(Include pregnancy within 3 months of death)

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? (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 E. M. Bartlett (M. D. or other)

Address Clarksville Mo Date signed 1/1/46

RECEIVED

District Health Officer No. 10

District File Number 1-46-10

Date Filed JAN 24 1946

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 *me*,
_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed

Harry Larroll

Licensed Embalmer No. 1439

P. O. Address

Clarksville 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. FebRegistration District No. 219Primary Registration District No. 445Registrar's No. 28

1. PLACE OF DEATH:

- (a) County Pike
 (b) City or town Clarksville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT
FULL NAME

- James F. Barner
 3. (b) If veteran _____ 3. (c) Social Security
 name war _____ No _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married
 divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 alive _____ years

7. Birth date of deceased no 18
 (Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____ (less than one day)
 min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant _____

- (b) Address _____

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

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) 1-3-46 (b) Dude Rickard
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Year 1945 Hour _____ Minute _____ M.
 21. I hereby certify that I attended the deceased from _____, 19____
 that I last saw him _____, 19____
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

- Due to _____

- Due to _____

- Other conditions _____
 (Include pregnancy within 3 months of death)

- Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

36607