

FILED MAR 20 1946

Registration District No. 347

Primary Registration District No. 6172

Registrar's No.

1. PLACE OF DEATH:

- (a) County Stone
(b) City or town Washington P. Rural
(c) Name of hospital or institution: 1
(If outside city or town limits, write "RURAL" and name of township)

(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

LONNIE LEE BARNES

3. (b) If veteran,
name war.

3. (c) Social Security
No.

4. Sex MO 5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive. years
7. Birth date of deceased. FEB 9 1946
(Month) (Day) (Year)

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

9. Birthplace Stone Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

12. Name LESTER BARNES
13. Birthplace Stone Co. Mo
(City, town, or county) (State or foreign country)
14. Maiden name DOROTHY PATRICK
15. Birthplace STONE Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant LESTER Barnes
(b) Address Galena MO RR3
17. (a) Burial (b) Date thereof Feb 22-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Yocum Pond Cemetery EVERETT Cheatham

18. (a) Signature of funeral director Galena Mo
(b) Address

19. (a) Feb 13 1946 (b) Lena Barnes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Stone
(c) City or town Washington P. Rural
(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 day 22
year 1946 hour 6 minute 20 A. M.
21. I hereby certify that I attended the deceased from Feb 21/1946
that I last saw him alive on Feb 22
and that death occurred on the date and hour stated above.

Immediate cause of death Indigestion + Enterocolitis Duration 4 hrs

Due to
Due to

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

Major findings:
Of operations 1190
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) (c) Means of injury
23. Signature R.S. Shumate, M.D. (M. D. or other)
Address Reeds Spring Mo Date signed 2/27/46

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.....

Everett J. Cheatham

Licensed Embalmer No. *3876*

P. O. Address *Galena 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.