S. No. 2
—12-45
5-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 20 1947

Registration District No. ____

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1712

State File No. ____

Primary Registration District No. 3040

Registrar's No. 5

1. PLACE OF DEATH:

(a) County: Livingston

(b) City or town: Chillicothe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 404 Third Street
(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)
In this community: 45 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Livingston

(c) City or town: Chillicothe
(If outside city or town limits, write "RURAL")

(d) Street No.: 404 Third Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Sarah Elizabeth Barnes

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: James Barnes

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

7. Birth date of deceased: July (Month) 10 (Day) 1893 (Year)

8. AGE: Years 53 | Months 5 | Days 27 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business ____

MOTHER FATHER

12. Name: Perry Johnson

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

14. Maiden name: Frances Johnson

15. Birthplace: Jamesport (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mrs. Dorothy Ryan

(b) Address: Chillicothe, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-11-47 (Month) (Day) (Year)

(c) Place: burial or cremation: Forrest Park Cemetery

18. (a) Signature of funeral director: Norman Funeral Home

(b) Address: Chillicothe, Missouri

19. (a) Jan - 9 - 47 (Date received local registrar) (b) Frances B. Neill (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: January day: 7th year: 1947 hour: 10 minute: 30 A.M.

21. I hereby certify that I attended the deceased from Aug, 1946, to Jan. 7, 1947; that I last saw her alive on 6 Jan, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis — Duration: ?

Due to: Diabetes mellitus — Duration: ?

Due to ____

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

Major findings:
Of operations ____
Of autopsy: 0

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature: Joseph F. Gale (M. D. or other) M.D.

Address: Chillicothe Mo. Date signed: 8 Jan 1947

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(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Elton F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.