

FILED AUG 4 1947

Registration District No. 2

Primary Registration District No. 6115

Registrar's No. 64

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

1. PLACE OF DEATH: Scott

(a) County Scott

(b) City or town Rural Westland

(c) Name of hospital or institution: Sikeston #1

(d) Length of stay: In hospital or institution 17 yr

In this community 17 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott

(c) City or town P.O. Sikeston

(d) Street No. 100

(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME MELLIE ANN 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 Robert Wm.

6. (c) Age of husband or wife if alive 23 years

7. Birth date of deceased Sept 23 1873

8. AGE: Years 73 Months 9 Days 27

If less than one day — hr. — min.

9. Birthplace Crittenden Co Ky

10. Usual occupation H.W.

11. Industry or business J

MOTHER FATHER { 12. Name Minnery

13. Birthplace Wark

14. Maiden name Wark

15. Birthplace Wark

16. (a) Informant Clyde Barnes

(b) Address Sikeston P.O.

17. (a) Burial (b) Date thereof 7-22-47

(c) Place: burial or cremation Sikeston Mo

18. (a) Signature of funeral director Walter Howard Home

(b) Address Sikeston Mo

19. (a) 7-27-47 (b) Mr. J. E. Henry

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20

year 1947 hour 12 minute 50 P. M.

21. I hereby certify that I attended the deceased from July 15 1947

that I last saw her alive on July 15 1947

and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma left maxilla

Duration 2 yrs.

Due to —

Due to —

Other conditions —

Major findings: Of operations 450

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? —

(d) Did injury occur in or about home, on farm, in industrial place, in public place? —

While at work? — (Specify type of place)

Means of injury —

23. Signature A.D. Wagner (M. D. or other) MD

Address Sikeston Date signed 9-26-47

RECEIVED

District Health Office No. 2

District File Number 242-103

Date Filed 2-31-47

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 *Raymond Lewis*  
Licensed Embalmer No. *3467*  
P. O. Address *Sekeston 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.