

FILED DEC 8 1947

Primary Registration District No. **300.3**

Registrar's No. **82**

1. PLACE OF DEATH:

(a) County **Barry**
 (b) City or town **Mahesh**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **St Vincent Hosp**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Lawrence**
 (c) City or town **R 7 D Mt Pleasant**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1014** (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME **Curtis Wilson Barnes**

3. (b) If veteran, name war 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **11th** year **1947** hour **7 am** M.

21. I hereby certify that I attended the deceased from **11/5/47** to **11/11/47** that I last saw him alive on **11/11/47** and that death occurred on the date and hour stated above.

Immediate cause of death **Respiratory failure**

Due to **6 month fracture**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 **Frank H. Hunt** (M.D. or other)

Address **Mount Mo** Date signed

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

4. Sex **Male** 5. Color or race **wh** 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 **Nov 5 - 1947**
 (Month) (Day) (Year)

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

9. Birthplace **Mount Mo**
 (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name **George Barnes**

13. Birthplace **Lawrence Co Mo**
 (City, town, or county) (State or foreign country)

14. Maiden name **Sheldon**

15. Birthplace **Sheldon Iowa**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Geo Barnes**

(b) Address **Larsaple Mo**

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

(c) Place: burial or cremation **Larsaple Cem**

18. (a) Signature of funeral director **Richard W. West**

(b) Address **Larsaple Mo**

19. (a) **11-20-47** (b) **W. M. West**
 (Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 6r

District File Number 1247-125-5-

Date Filed DEC 3 1947

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.....

W.K. Jackson

Licensed Embalmer No. 3954

P. O. Address *Lanark Md*

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.