

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 21 1949

State File No. **26814**
3325

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY in this place <u>18 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>2447 Brooklyn Ave</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wheatly Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Carrie Barnes</u> b. (Middle) _____ c. (Last) <u>Appleton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July-31-1949</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept. 30-71</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Ranoke, Mo., U.S.A</u>	

13a. FATHER'S NAME <u>Thomas Newby</u>	13b. MOTHER'S MAIDEN NAME <u>Vinie Barnes</u>	14. NAME OF HUSBAND OR WIFE <u>Henry Appleton (Dec.)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>497-28-1836</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Bernice West</u>	ADDRESS <u>2449 Brooklyn</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sclerotic type heart</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myasthenia Gravis</u> DUE TO (c) <u>Prostatitis Cystitis</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>605 X</u>		

19a. DATE OF OPERATION <u>7-21-49</u>	19b. MAJOR FINDINGS OF OPERATION <u>Cystoscopic - Prostatic Cystitis</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from 7-13-1949, to 7-31-1949, that I last saw the deceased alive on 7-31-1949, and that death occurred at 8:20 m., from the causes and on the date stated above.

23a. SIGNATURE <u>P. C. Turner</u> (Type or Print)	23b. ADDRESS <u>1433 E. 19th</u>	23c. DATE SIGNED <u>8-1-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>August-24</u>	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) <u>Kirkville MO</u>
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DATE REC'D BY LOCAL REG. <u>8-2-49</u>	REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>	GENERAL DIRECTOR'S SIGNATURE <u>Walter J. Jones</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

.....
working under my personal supervision.

Student Embalmer No. _____

Signed _____

C. H. Skist

Signed.....
Student Embalmer

Licensed Embalmer No. _____

2210

P. O. Address _____

K. C. 740

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.