No. 300
10.48

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# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 33754

BIRTH NO. ____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4437

**1. PLACE OF DEATH**
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kansas City
c. LENGTH OF STAY (In this place) 3 YEARS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lakeside Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI
b. COUNTY JACKSON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) KANSAS CITY 53 8
d. STREET ADDRESS (If rural, give location) 1221 EAST 36TH ST.

**3. NAME OF DECEASED** (Type or Print)
a. (First) MRS
b. (Middle) DILLIE B
c. (Last) Barnes

**4. DATE OF DEATH** (Month) (Day) (Year) OCT.-16 1949

**5. SEX** Female
**6. COLOR OR RACE** White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) WIDOWED
**8. DATE OF BIRTH** AUG. 10 1869
**9. AGE** (In years last birthday) 80 | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) AT HOME
**10b. KIND OF BUSINESS OR INDUSTRY** —
**11. BIRTHPLACE** (State or foreign country) DEKALB, MO
**12. CITIZEN OF WHAT COUNTRY?** U.S.A

**13a. FATHER'S NAME** — ROGERS
**13b. MOTHER'S MAIDEN NAME** DEKALB WOODRING
**14. NAME OF HUSBAND OR WIFE** CHARLES BARNES

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) No. (If yes, give war or dates of service) ——
**16. SOCIAL SECURITY NO.** NONE
**17. INFORMANT'S SIGNATURE OR NAME** MR. C. M. BARNES **ADDRESS** 7921 CHESTNUT

**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.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Femur — INTERVAL BETWEEN ONSET AND DEATH: Aug. 24th to Oct. 16th-49

ANTECEDENT CAUSES

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Advanced Age and

DUE TO (c) Attendant Shock

II. OTHER SIGNIFICANT CONDITIONS

*Conditions contributing to the death but not related to the disease or condition causing death.* Cardiorenal Syndrome

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**19a. DATE OF OPERATION** Aug. 24-49
**19b. MAJOR FINDINGS OF OPERATION** Fracture Femoral Shaft of Inter Trochanteric
**20. AUTOPSY?** YES ☐ NO ☒

**21a. ACCIDENT / SUICIDE / HOMICIDE** (Specify)
**21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) Home
**21c. (CITY, TOWN, OR TOWNSHIP)** Kansas City **(COUNTY)** Jackson **(STATE)** Mo.
**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) Aug. 22-49 A.m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☒
**21f. HOW DID INJURY OCCUR?** fell in Home 123

**22.** *I hereby certify that I attended the deceased from* Aug 22 *19*49, *to* Oct 16th, *19*49, *that I last saw the deceased alive on* Oct 16th, *19*49, *and that death occurred at* 4:15 A *m., from the causes and on the date stated above.*

**23a. SIGNATURE** A.E. Linville **(Degree or title)** D.O.
**23b. ADDRESS** 612-12th Walnut Bldg. K.C. Mo.
**23c. DATE SIGNED** 10-17-49

**24a. BURIAL, CREMATION, REMOVAL** (Specify) BURIAL
**24b. DATE** OCT. 18, 1949
**24c. NAME OF CEMETERY OR CREMATORY** MT. MORA CEMETERY
**24d. LOCATION** (City, town, or county) ST. JOSEPH **(State)** Mo

**DATE REC'D BY LOCAL REG.** 10-18-49
**REGISTRAR'S SIGNATURE** Geraldine Holmes
**25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS** D.W. Newcomer's Sons 7331 Brush Creek Kansas City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 _____ Student Embalmer No. _____, working under my personal supervision.

Student _____
Student Embalmer

Signed Robert Ray

Licensed Embalmer No. 4162

P. O. Address Kansas City, 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.