

FILED FEB-14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

572

State File No.

BIRTH NO. _____ REG. DIST. NO. 73 PRIMARY REG. DIST. NO. 4133 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY <u>Clay</u> <u>1</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>mo</u> b. COUNTY <u>Clay</u>	
b. CITY OR TOWN <u>Kearney</u>	c. LENGTH OF STAY (in this place) <u>years</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kearney</u>	d. STREET ADDRESS (If rural, give location) <u>6000</u> <u>0</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Henry</u>	b. (Middle) <u>William</u>	c. (Last) <u>Barnes</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb</u> <u>1</u> <u>1955</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>April 4 1905</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 10 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <u>Section Hand R.R. Section Man</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Clay co mo</u>	11. BIRTHPLACE (State or foreign country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Bosley Barnes</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Jane Keith</u>	14. NAME OF HUSBAND OR WIFE <u>Ellen Barnes</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. <u>707-09-525</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Myrtle Handy</u>	ADDRESS <u>Kearney, Mo</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 yrs.</u> <u>2 yr.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Coronary episodes in 1953</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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
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22. I hereby certify that I attended the deceased from 18 March 1953 to 1 Feb 1955, that I last saw the deceased alive on 15 Jan 1955, and that death occurred at 6:45 A. M., from the causes and on the date stated above.

23a. SIGNATURE <u>J. M. Storman, M.D.</u> (Degree or title)	23b. ADDRESS <u>Liberty, Mo</u>	23c. DATE SIGNED <u>2 Feb 55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb 4 55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	24d. LOCATION (City, town, or county) (State) <u>Kearney Mo</u>
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DATE REC'D BY LOCAL REG. <u>Feb. 7, 1955</u>	REGISTRAR'S SIGNATURE <u>Mabel Graham</u> <u>491</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard Fry</u>	ADDRESS <u>Kearney, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

DEC 3 1957

EMMA F. YANT

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 _____

C. H. Wise

Licensed Embalmer No. *2590*

P. O. Address: *Smickville Pa*

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.