

Health, Welfare, Public Service
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 -57
 MEDICAL CERTIFICATION
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Robert H. Finkle
 All diseases in Part I must be causally related.

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

31688
 STATE FILE NUMBER
 4201

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY HACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY HACKSON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6509 EAST 37th ST.		Length of stay in lb 6 mos.		d. STREET ADDRESS (If outside, give location) 6509 EAST 37th ST.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle EUGENE Last BARNES				4. DATE OF DEATH Month SEPT. Day 8 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1891		9. AGE (In years last birthday) 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (City and state or country) SIOUX FALLS, SO. DAKOTA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME VALENTINE BARNES			13b. MOTHER'S MAIDEN NAME JEAN SEYMOUR		14. NAME OF husband OR WIFE Lillian M. BARNES		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 504-01-9889		17. INFORMANT Mrs. Lillian M. BARNES		Address 6509 E. 37th ST. K.C., MO-	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Primary carcinoma of prostate DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 177	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ o.m. _____ p.m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 5 Sept, 1897 to 8 Sept, 1957 and last saw him alive on 5 September, 1957 Death occurred at 4:50 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Robert H. Finkle M.D.				22b. ADDRESS Raytown, Mo.		22c. DATE SIGNED 9/8/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE SEP. 8, 1957	23c. NAME OF CEMETERY OR CREMATOR MT. PLEASANT		23d. LOCATION (City, town, or county) (State) SIOUX FALLS, SO. DAKOTA		
24. FUNERAL DIRECTOR P.W. NEWCOMER'S SONS			ADDRESS K.C., Mo.		25. DATE RECD. BY LOCAL REG. 9-8-57		26. REGISTRAR'S SIGNATURE Reva Minshel

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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
Signature of Student Embalmer

Signed *Basil V. Honey*

Licensed Embalmer No. *4724*

P. O. Address *St. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.