

No. 2
1-4-4
1-17-39
X26390

State File No. _____

FILED MAY 13 1943

Registrar's No. _____

Registration District No. _____

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County BUCHANAN

(b) City or town ST. JOSEPH

(c) Name of hospital or institution: Mo State Hosp #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 127 days
(Specify whether years, months or days)

In this community 127 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1301 Monroe Ave
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JASPER BARNHARDT

3. (b) If veteran. _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17
year 1943 hour 14:30 minute _____ P. _____ M.

4. Sex M 5. Color or race Wh 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife no record 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 29, 1877
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 20 1943 to April 17 1943
that I last saw him alive on April 17 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia Duration 1 wk

8. AGE: Years Months Days If less than one day

70 8 19 _____ hr. _____ min.

Due to _____

Due to _____

9. Birthplace Camden Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter & Farmer

Other conditions Bronchitis & Coronary artery - scl ?
(Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name Mary Barnhardt

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

14. Maiden name Mary Jane Dillard

15. Birthplace Cole Co. Mo
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____

Of autopsy _____

16. (a) Informant Mo. St. Hosp #2, records of

(b) Address St. Joseph, Mo.

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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 _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

23. Signature W. G. Rowe (M. D. or D. O.)
Address Mo. St. Hosp #2, St. Joseph, Mo. Date signed 4-17-43

1233

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

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{will be} ~~was~~ embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Fred E Wilkinson

Licensed Embalmer No.....

P. O. Address Clinton, 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.