

FILED OCT 19 1948

Registration District No. 37

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32694

Primary Registration District No. 3023

Registrar's No. 209

1. PLACE OF DEATH:

(a) County Henry
 (b) City or town Clinton MO
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: General Hospit
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 hrs (Specify whether)
 In this community Life
 years, months or days

3. (a) PRINT FULL NAME J. MARY LEE BARNARD3. (b) If veteran,
name war No3. (c) Social Security No.
None

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife
 6. (c) Age of husband or wife if
 alive..... years
 7. Birth date of deceased 6 4 48
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		4	6	hr. min.

9. Birthplace Winch MO
(City, town, or county) (State or foreign country)10. Usual occupation Infant

11. Industry or business

12. Name Johanne Barnard13. Birthplace Quind City MO
(City, town, or county) (State or foreign country)14. Maiden name Mary Josephine15. Birthplace near Winch MO (attn)
(City, town, or county) (State or foreign country)16. (a) Informant Johanne Barnard(b) Address Winch MO17. (a) Rural (b) Date thereof 10 11 - 48
(Burial, cremation or removal) (Month) (Day) (Year)(c) Place: burial or cremation Winch Cemetery18. (a) Signature of funeral director W. J. Brown(b) Address Winch MO19. (a) 10-12-48 (b) R. R. Kenney
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry 47
 (c) City or town Winch 3
 (If outside city or town limits, write "RURAL")
 (d) Street No. Rural
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 10
year 1948 hour 1:25 minute P.M.21. I hereby certify that I attended the deceased from OCT. 10
8 A.M. 1948, to TIME OF DEATH
that I last saw him alive on 10 OCT. 1948
and that death occurred on the date and hour stated above.Immediate cause of death PNEUMONIADue to EXPOSURE AND MALNUTRITION

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)Major findings: NONEOf operations NONEOf autopsy NONE PERFORMED

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?.....

While at work?..... (Specify true of place)

(e) Means of injury 023. Signature Hugh B. Walker, M. D. or other) MDAddress Clinton, MO Date signed 11 OCT. 1948

MOTHER FATIGUE

WRITE PLAINLY—USING UNFADING BLACK INK—PLEASE PRINT FULLY

RECEIVED

District Health Officer No. 7,

District File Number 9-48-1212

Date Filed 10-18-48

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 _____

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

Signed R. R. Kenney

Licensed Embalmer No. 3099

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.

Registration District No. 137

Primary Registration District No. 2023

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Jimmy L Banaud

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June
(Month) (Day) (Year)

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

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

BRONCHIAL PNEUMONIA

Due to _____

Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Hugh B Walker (M. D. or other) M.D.
Address Clinton, Mo. Date signed 1 Nov 1946

SUPPLEMENTARY

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

S-3269A