

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 19 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

35-460-B

1. PLACE OF DEATH
County Ruchonan Registration District No. 85
Township St Joseph Primary Registration District No. 1001
City St Joseph (No. State Hospital #2) St. _____ Ward _____
2. FULL NAME Frank Barnes ~~Barner~~
(a) Residence. No. State Hospital #2 St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
Registered No. 1312
St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>M</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>about</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown 1876</u>				
7. AGE	YEARS <u>54</u>	MONTHS <u>Unknown</u>	DAYS <u>Unknown</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>				
PARENTS	10. NAME OF FATHER <u>Unknown</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>			
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>			
14. INFORMANT <u>State Hospital Records</u> (Address) <u>St Joseph Mo</u>				
15. FILED <u>John G. 25th</u> REGISTRAR				

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH (MONTH, DAY AND YEAR) <u>Nov 27</u>	19 <u>30</u>
17. I HEREBY CERTIFY, That I attended deceased from <u>Oct 29</u> , 19 <u>29</u> , to <u>Nov 27</u> , 19 <u>30</u> , that I last saw him alive on <u>Nov 26</u> , 19 <u>30</u> , and that death occurred, on the date stated above, at <u>1:30 a</u> m.	
THE CAUSE OF DEATH* WAS AS FOLLOWS: <u>Cerebral Syphilis</u>	
34	(duration) yrs. mos. ds.
35	(duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH..... 8 DID AN OPERATION PRECEDE DEATH?..... DATE OF..... WAS THERE AN AUTOPSY?..... WHAT TEST CONFIRMED DIAGNOSIS..... (Signed) <u>D. B. Miles</u> M. D. <u>Nov 27, 1930</u> (Address) <u>St Joseph Mo</u>	
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>State Hospital Burial</u>	DATE OF BURIAL <u>12-9-30</u>
20. UNDERTAKER <u>B. F. Graves Funeral Home</u>	ADDRESS <u>806 S 17 S</u>

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