

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 709

Primary Registration District No. _____

Registrar's No. 861

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
BARNES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 16 days
 In this community _____
 years, months or days 1-52

8. (a) PRINT FULL NAME Frank Claude Barnes

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

4. Sex male
 5. Color or race white
 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife Charlet Barnes
 6. (c) Age of husband or wife if alive 27 years
 7. Birth date of deceased March 11 1914
 (Month) (Day) (Year)

8. AGE: Years 25 Months 10 Days 7
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Lawyer

11. Industry or business _____

MOTHER FATHER
 12. Name J. A. Barnes
 13. Birthplace Carmi Ill
 14. Maiden name Elizabeth Brown
 15. Birthplace Blinton Co. Ky
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Frank C. Barnes
 (b) Address Carmi Ill.

17. (a) removal (b) Date thereof Jan 21, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Carmi, Ill.

18. (a) Signature of funeral director H. M. Archer
 (b) Address Carmi, Ill.

19. (a) JAN 29 1940 (b) _____
 (Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County White
 (c) City or town Carmi NR
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 18th
 year 1940 hour 9:05 minute _____ P.M.

21. I hereby certify that I attended the deceased from
1-2-1940 to 1-18-1940
 that I last saw him alive on 1-18-1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Subacute Bacterial Endocarditis Duration 9 mos
 Due to Rheumatic Heart Disease 13 yrs
disease

Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy _____
 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 Alf Mueller (M. D. or other) _____
 Address BARNES HOSPITAL Date signed 1/18/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1 X 1031

861

861

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.