

Registration District No. 85

Primary Registration District No. 1001

1112

NOV 19 1940

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

1. PLACE OF DEATH

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 days (Specify whether  
In this community 9 days  
years, months or days)

3. (a) PRINT FULL NAME Bert Alvin Barnes

3. (b) If veteran, name war none 3. (c) Social Security No. none

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

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive 10 years

7. Birth date of deceased October 10 1940  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 9 If less than one day hr. min.

9. Birthplace St. Joseph Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation none (Infant)

11. Industry or business

12. Name Bert A. Barnes

18. Birthplace Fresno Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Leah McLean

15. Birthplace St. Joseph Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Bert A. Barnes

(b) Address 1021 3/4 St. Joseph

17. (a) Burial (b) Date thereof 10/20/40  
(Place, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crematorium

18. (a) Signature of funeral director H. A. Sullivan

(b) Address Gower

19. (a) Oct. 19, 1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town 1021 3/4 St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1021 No. 40  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 19  
year 1940 hour 12 minute 01 A.M.

21. I hereby certify that I attended the deceased from October 10, 1940, to October 19, 1940, that I last saw him alive on October 19, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition Duration 8 days

Due to Intestinal Obstruction 8 days

Due to Malformation 8 days

Other conditions Intestinal

Major findings: Of operations 157A

Of autopsy Obstruction, Malformation, Malnutrition, Dehydration.

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? 85  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 263 - 30th Street St. Joseph Mo. Date signed 10-19-40

Duration  
8 days  
8 days  
8 days  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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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.....

....., 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.**