

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42558**
Registrar's No. **1034**

Registration District No. **318**

Primary Registration District No. **2001**

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

1. PLACE OF DEATH:

(a) County Green

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1321 La Fontaine
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community 17 years
years, months or days)

3. (a) PRINT FULL NAME AGNES EDITH BARNES

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John Barnes

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased December 16 1877
(Month) (Day) (Year)

8. AGE: Years 1 63 Months 0 Days 10
If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business None

12. Name Washington Link's

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

14. Maiden name (Unknown) Condray

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

16. (a) Informant John Barnes

(b) Address 1321 La Fontaine Sp. Mo

17. (a) Burial (b) Date thereof Dec. 27 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn

18. (a) Signature of funeral director F. E. Ujeme

(b) Address Springfield Mo

19. (a) 12-27-40 (b) W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Green

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

(d) Street No. 1321 La Fontaine
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26th
year 1940 hour 11:55 minute A. M.

21. I hereby certify that I attended the deceased from Nov 26, 1940, to Dec 26, 1940;
that I last saw her alive on Dec 26, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 7 days

Due to Hypertension Essential

Due to _____

Other conditions Chronic Bronchietasis
(Include pregnancy within 3 months of death)

Major findings: Of operations J.P.K.

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?
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While at work? _____ (Specify type of place)

(e) Means of injury _____

Signature R. Ned White (M. D. or other)

Address Springfield Date signed 12/26/40

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. H. Greene*

Licensed Embalmer No. *3681*

P. O. Address *Springfield, 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.

X