

No. 2
4-13-40
5-17-39
DI X28159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40988

State File No.

1940 JAN 24 1942

Registration District No. 397

Primary Registration District No. 1002

Registrar's No. 1666

48
3
8

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Jackson City

(c) Name of hospital or institution: St. E. St. Hosp. 1
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 45 days
(Specify whether years, months or days)

In this community 4 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 3615 Forest St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. 10 years.

3. (a) PRINT FULL NAME JOHN BARNETT

3. (b) If veteran, name war.....

3. (c) Social Security No. unk

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased March 10 1910
(Month) (Day) (Year)

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

31 9 5 hr. min.

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

10. Usual occupation none

11. Industry or business

12. Name John Barnett

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

14. Maiden name John Paul

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

16. (a) Informant Record Clerk

(b) Address St. E. St. Hosp. 1

17. (a) Removal (b) Date thereof 12-16-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary MO

18. (a) Signature of funeral director William Paul

(b) Address Calvary MO

19. (a) Dec 16 1941 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day Dec
year 1941 hour 9 minute 35 A.M.

21. I hereby certify that I attended the deceased from 11
1 - 1941, 19 to 12-16-41
that I last saw him alive on 12-16-41, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Toxic Hepatitis with hypostatic congestion and edema of lungs

Duration

Due to.....

Due to.....

Other conditions ll
(Includes pregnancy within 3 months of death)

Major findings: ll
Of operations

Of autopsy See above

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.....

33. Signature Drury R. Thor (M. D. or other) 0

Address..... Date signed.....

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. *4078*

P. O. Address. *Kan City, Kan*

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.