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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No. 3592

FILED SEP 18 1945

Registration District No.

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson

(a) County: Jackson

(b) City or town: K. C.

(c) Name of hospital or institution: Menorah Hospital

(d) Length of stay: 27 Hours

In this community: 30 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Jackson

(c) City or town: K. C.

(d) Street No.: 3015 E. 6th.

(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME: Charles Murray Barnett

(b) If veteran, name war: No

(c) Social Security No.: None

4. Sex: Male

5. Color or race: W

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

6. (b) Name of husband or wife: Pansy T. Barnett

6. (c) Age of husband or wife if alive: 72 years

7. Birth date of deceased: June 2, 1871

8. AGE: Years 74, Months 2, Days 25

9. Birthplace: Crofton Kentucky

10. Usual occupation: Retired Barber

11. Industry or business:

12. Name: Unknown

13. Birthplace: Unknown

14. Maiden name: Unknown

15. Birthplace: Unknown

16. (a) Informant: H. C. Barnett

(b) Address: Memphis, Tenn.

17. (a) Burial (b) Date thereof: Aug. 29, 1945

(c) Place: Mt. Washington Cem.

18. (a) Signature of funeral director: [Signature]

(b) Address: 2825 Independence Blvd.

19. (a) 8-29-45 (b) [Signature] Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 27 year 1945 hour 7 minute 35 P. M.

21. I hereby certify that I attended the deceased from Aug 26, 1945 to Aug 27, 1945

that I last saw h.l. in alive on Aug 27, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia, Circulatory failure, arteriosclerosis

Due to: arteriosclerosis

Due to:

Other conditions:

Major findings: Of operations: Of autopsy:

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: [Signature] (M. D. or other)

Address: [Address] Date signed: [Date]

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

*Handwritten signature*

**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 *H.D. Blackman*

Licensed Embalmer No..... 3639

P. O. Address..... Kansas City 1, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3592

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: Menorah Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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.

3. (a) PRINT FULL NAME

Charles Murray Barnett

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_

5. Color or race \_\_\_\_\_

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_

(b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 8-29-45

(Date received local registrar)

Geraldine Holmes  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 27  
year 1945 hour 7 minute 35 P. M.

21. I hereby certify that I attended the deceased from Aug 26 1945 to 8-27 1945  
that I last saw alive on 8-27 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis  
Due to \_\_\_\_\_

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

Major findings: 97  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration

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 J. S. Hoffman (M. D. or other) \_\_\_\_\_  
Address 1408 Ardyle Bldg Date signed 8-28-45

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