

UNITED STATES HEALTH DEPARTMENT
STANDARD CERTIFICATE OF DEATH

FILED MAR 27 1946
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 hrs. 40 mins
(Specify whether years, months or days)

In this community 54 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Cecil Mae Barnes

3. (b) If veteran, name war No

3. (c) Social Security No. -none

4. Sex Fe. / 5. Color or race White

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

6. (b) Name of husband or wife Leonard S.

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Oct. 7, 1891
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>54</u>	<u>5</u>	<u>3</u>	<u>hr. min.</u>

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

10. Usual occupation Homemaker

11. Industry or business -

MOTHER FATHER { 12. Name W. W. Wright

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

14. Maiden name Unknown

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

16. (a) Informant Leonard S. Barnes

(b) Address 1911 Indiana

17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof 3/12/46
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.

(b) Address Kansas City, Mo.

19. (a) 3-13-46
(Date received local registrar) (b) Eraldine Holmes
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 1911 Indiana
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10
year 1946 hour 3 minute 0 P. M.

21. I hereby certify that I attended the deceased from March
10, 1946 to 3-10, 1946
that I last saw her alive on 3-10, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Adhesion between ileum and transverse colon with obstruction and gangrenous ileitis

Due to _____

Due to _____

Other conditions 12282
(Include pregnancy within 3 months of death)

Major findings: See above

1 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? _____

23. Signature Clark W. Holmes
(Specify type of place) (M. D. or other)
Address Med. Dir. Gen'l Hosp. Date signed 3-11-46

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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..... *W. B. Blackman*

Licensed Embalmer No. *3639*

P. O. Address..... *K. C. 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.