

S. No. 30  
OM-10-47  
5-17-39  
I 3908

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED APR 24 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 124099  
Registrar's No. 1592

Registration District No. 749

Primary Registration District No. 1002

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 19 1/2 hrs.  
(Specify whether  
In this community 25 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2705 Linwood  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Minnie Barnes  
3. (b) If veteran, name war No  
3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 11  
year 1948 hour 5 minute 26 P. M.

4. Sex FEM / 5. Color or race W  
6. (a) Single, widowed, married, divorced WIDOW  
6. (b) Name of husband or wife FRANK L. BARNES  
6. (c) Age of husband or wife if alive 18 years  
7. Birth date of deceased November 18, 1874  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 10, 1948, to April 11, 1948  
that I last saw her alive on April 11, 1948  
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 4 Days 13  
If less than one day hr. no min. 0

Immediate cause of death  
Left and right heart failure superimposed on a heart damaged by old infarctions  
Due to \_\_\_\_\_

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

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 7/10  
Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name DR. C.M. Williams  
13. Birthplace Alabama  
(City, town, or county) (State or foreign country)

Of autopsy See above  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

14. Maiden name Lella Owens  
15. Birthplace So. Carolina  
(City, town, or county) (State or foreign country)  
16. (a) Informant Cazey L. Motley  
(b) Address Liberty, Mo  
17. (a) REMOVAL (b) Date thereof 4 12 48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation LIBERTY, MO

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? \_\_\_\_\_

18. (a) Signature of funeral director STINE & McCLURE  
(b) Address 3235 GILLHAM PLAZA  
19. (a) 4-12-48 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury 0  
23. Signature Wm W. Hart (M. D. or other) MD  
Address Med. Dir. Gen'l Hosp. Date signed 4-12-48

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

18  
3  
8

FEB 27 1950

*Dr. Williams*

MAY 6 1948

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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.....

*Robert H Reed*

Licensed Embalmer No. *2748*

P. O. Address *H. C. Inc.*

**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.**