MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

38387

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. 3622 Montana St. St. ..... Ward)

File No. ..... Registered No. 11053

2. FULL NAME Joseph J. Barry

(a) Residence. No. 3622 Montana St. St., 15 Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch. 16th. 1864

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	63	8	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Maintenance Man

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Grand Leader

9. BIRTHPLACE (CITY OR TOWN) .....

(STATE OR COUNTRY) Ireland

PARENTS

10. NAME OF FATHER Thos. Barry

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....

(STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Ellene Tobin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....

(STATE OR COUNTRY) Ireland

14. INFORMANT Mrs. J. W. Rothschilds

(Address) 3622 Montana St.

15. FILED DEC 10 1927, 19..... Max C Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 9th. 1927

17. I HEREBY CERTIFY, That I attended deceased from 12/8/, 1927, to 12/9/, 1927 that I last saw him alive on 12/9/27, 19..., and that death occurred, on the date stated above, at 6 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemmorrhage, Apoplexy

97 (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) Arterio Sclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Yes

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? Physical Exam.

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) A. Hofmeister, M. D

12/10/, 1927 (Address) 3958 S. Broad Bl.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary

DATE OF BURIAL Dec. 12th. 27

20. UNDERTAKER Wm. Schumacher

ADDRESS 3013 Meramec

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.