

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City **ST. LOUIS MO.**

**791**  
**1000**

Registration District No.....  
Primary Registration District No.....  
(No. **CENTRAL HOSPITAL.**)

**3882**  
**1127**

File No.....  
Registered No.....  
St..... Ward)

**2. FULL NAME** **HARRIET BARBER.**

(a) Residence. No. **4129 SAN FRANCISCO AVE.** St. **10** Ward.....  
(Usual place of abode)

(If nonresident, give city or town and State)

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>FEMALE.</b>	4. COLOR OR RACE <b>WHITE.</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>MARRIED.</b>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>ARCH BARBER.</b>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <b>4/30/1898.</b>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<b>32</b>	<b>8</b>	<b>28</b>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <b>HOUSEWIFE. 735</b> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **1/28/31** 19..

17. I HEREBY CERTIFY, That I attended deceased from **Jan 26**, 19.. to **Jan 28**, 19.. that I last saw him alive on **Jan 28**, 19.., and that death occurred, on the date stated above, at **2-30** A. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Acute Intestinal Obstruction due to adhesions, cause unknown** (duration) yrs. mos. **2** ds.

CONTRIBUTORY (SECONDARY) **1/22/31** (duration) yrs. mos. ds.

18. WHERE AND DISEASE CONTRACTED **1228 B**  
IF NOT A PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **Jan 28/31**  
WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **Specimen**  
(Signed) **H. C. Bohrer** M. D.  
**1/28, 1931** (Address) **315 University Club Bldg**

9. BIRTHPLACE (CITY OR TOWN) **ST. LOUIS.**  
(STATE OR COUNTRY) **MISSOURI.**

10. NAME OF FATHER **WM H. SCHWIDDE.**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **ST. LOUIS MO.**  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **JULIA WARNICK.**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **ILLINOIS.**  
(STATE OR COUNTRY)

14. INFORMANT **Arch Barber**  
(Address) **4129 San Francisco Ave.**

15. FILED **29** 19.. **May** **C. Starck**  
REGISTRAR

\*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 **VALHALLA CEMETERY.** DATE OF BURIAL **1/30/31**  
20. UNDERTAKER **Pravast Und. Co** ADDRESS **3710 N. Grand**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

*University 1931*

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.

