FILED APR 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9497

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2980

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Homer G Philips Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution / (Specify whether

In this community 25 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouria (b) County

(c) City or town St Louis 22 (If outside city or town limits, write "RURAL")

(d) Street No. 2715 Clark Ave (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ellen Barry

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female

5. Color or race Col

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

6. (b) Name of husband or wife Lewis Barry

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

7. Birth date of deceased Unknown (Month) (Day) 1868 (Year)

8. AGE: Years About 72 Months Days If less than one day hr. min.

9. Birthplace Columbia (City, town, or county) Miss (State or foreign country)

10. Usual occupation House Work

11. Industry or business

FATHER 12. Name Beverly Isom

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

MOTHER 14. Maiden name Unknown

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

16. (a) Informant's own signature Henry Barry

(b) Address 2715 Clark Ave

17. (a) Buriel (Burial, cremation, or removal) (b) Date thereof Mar 30-40 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director J. W. Hughes

(b) Address 2620 Lawton

19. (a) MAR 30 1940 (Date received local registrar) (b) J. F. Bredech (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Marth day 25th year 1940 hour 3 minute 30 P M.

21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw h..... alive on ....., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Fractured left hip; Aortic Stenosis; Coronary Occlusion; suffered in fall in areaway in rear of 237 So. Beaumont, about 8.30 PM February 24th, 1940. ACCIDENT. — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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) ACCIDENT

(b) Date of occurrence 2/24/1940

(c) Where did injury occur? St. Louis, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? public place (Specify type of place)

While at work? (e) Means of injury

23. Signature Joseph [illegible] (Coroner)

Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

MARGIN RESERVED FOR BINDING

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.

50M-5-17-39 Rev. 5-17-39

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 Lyda Hughes

Licensed Embalmer No. 2938

P. O. Address St Louis

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, above space should be left blank.