

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4679

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (c) Name of hospital or institution: Peoples Hosp. 3447 Pine St.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days (Specify whether  
 In this community 4 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County Madison  
 (c) City or town Madison NR  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1820 Jefferson  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

8. (a) PRINT FULL NAME ROXANA BARBER, 616

8. (b) If veteran, name war none 8. (c) Social Security No. none

4. Sex Female 5. Color or race Colored  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Willis Barber 6. (c) Age of husband or wife if alive 67 years  
 7. Birth date of deceased Dec 1 1872  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
67 5 23 hr. min

9. Birthplace Fulton Mo.  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife at home

11. Industry or business  
 12. Name Henry Kobby  
 13. Birthplace Platte Co. Mo.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Nancy Churchwell  
 15. Birthplace Platte Co. Mo.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Willis Barber

(b) Address Madison Ill.

17. (a) Burial (b) Date thereof May 30 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fulton Mo.

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

(b) Address 2205 Mo. Ave. East St. Louis

19. (a) MAY 28 1940 (b) J. J. Backus  
 (Date of registration) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24  
 year 1940 hour 63 minute 7 P. M.

21. I hereby certify that I attended the deceased from Aug. 27, 1939, to May 24, 1940;  
 that I last saw her alive on MAY 24, 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Encephalorrhagia  
 Duration 9 Mo.

Due to Hypertension

Due to None

Other conditions None  
 (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy None

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)  
 Means of injury \_\_\_\_\_

23. Signature J. J. Backus (M.D. or other) MD  
 Address Madison Ill. Date signed 5-27-40

Duration

9 Mo.

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

USE PREVIOUS EDITIONS OF THIS FORM CAREFULLY. MAKE A PERMANENT RECORD

**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 St. Powell.*

Licensed Embalmer No..... *3402*

P. O. Address..... *3100 Franklin*

**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.**