

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 26823

REG SEP 25 1940
Registration District No. 791

Primary Registration District No. Registrar's No. 6719

1. PLACE OF DEATH:

(a) County _____
(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Saint Louis Maternity Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community 4 years
years, months or days)

3. (a) PRINT FULL NAME Barbara Louise Rhymes 520

3. (b) If veteran, name war nil 3. (c) Social Security No. nil

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Henry 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased September 23, 1909
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 10 15 hr. min.

9. Birthplace Galveston, Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Herman H. Bernau
18. Birthplace New York, New York
(City, town, or county) (State or foreign country)
14. Maiden name Antoniou
15. Birthplace Galveston, Texas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Barbara Rhymes

(b) Address 630 So. Kings Highway Blvd.

17. (a) Burial (b) Date thereof 8 9 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Alexander, La.

18. (a) Signature of funeral director W. H. Brown

(b) Address 4259 Lunder Blvd

19. (a) AUG 7 1940 (b) J. G. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town Saint Louis 19
(If outside city or town limits, write "RURAL")
(d) Street No. 322 North Boyle Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7
year 1940 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from Aug 5, 1940, to Aug 7, 1940;
that I last saw her alive on August 7, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death
Puerperal Hemorrhage
Obstetrical Shock
Due to Placenta praevia 2 da

Due to _____
Other conditions (Include pregnancy within 3 months of death)

Major findings: Placenta praevia
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)
(e) Means of injury 1
23. Signature J. H. Brown (M. D. or other) M.D.
Address 630 So. Kings Highway Blvd Date signed 8-7-40

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

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.

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144.0

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 Howard F Rowland

Licensed Embalmer No. 3114

P. O. Address St Louis Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26873
Registrar's No. 6719

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME..... Barbara L. Rhymes

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... F 5. Color or race..... w
6. (a) Single, widowed, married, divorced..... m

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

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

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

17. (a) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 10-24-40 (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH..... Month..... day..... year..... hour..... minute..... M.

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

Immediate cause of death.....
Pre-eclampsia
Placenta previa
Due to.....
Delivery 8-7-1940

Other conditions..... (Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....

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?
..... (Specify type of place)
While at work?..... (e) Means of injury.....
23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTAL

1442

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOORE

