

Registration District No. **791 I**

Primary Registration District No. **1003**

Registrar's No.

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County _____
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **5635 CHAMBERLAIN**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** day **24**
year **1940** hour **3** minute **00** P. M.

21. I hereby certify that I attended the deceased from
DECEMBER 22, 1940 to **DECEMBER 24, 1940**;
that I last saw her alive on **DECEMBER 24, 1940**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of**
esophagus + emphysema

Due to **Carcinoma of Intestines**

Other conditions **Path. fract. of left femur**

Major findings: **none**

Of autopsy **Metastatic carcinoma of liver, lungs, l. nodes, etc.**

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 **Wesley A. Barton** (M. D. or other)
Address **D. BARNES HOSPITAL** Date signed **12-24-40**

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

3. (a) PRINT FULL NAME **CAROLYN ESTHER McLAUGHLIN**

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

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

6. (b) Name of husband or wife **I** 6. (c) Age of husband or wife if alive **X** years

7. Birth date of deceased **July 17 1878**
(Month) (Day) (Year)

8. AGE: Years **62** Months **0** Days **7** If less than one day hr. min.

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

10. Usual occupation **Home Keeper**

11. Industry or business _____

12. Name **Les R. McLaughlin**

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

14. Maiden name **Frances Leach**

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

16. (a) Informant **Maudie M. Day**

(b) Address **5635 Chamberlain Cir.**

17. (a) **Removal** (b) Date thereof **Dec. 24-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

(b) Address **Manchester, N.H.**

19. (a) **DEC 21 1940** (b) **J. W. Bridget**
(Date of death) (Registrar's signature)

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

MOYER FATHER

10852

10801

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.....

Arnold W. Schuene

Licensed Embalmer No.....

3864

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, fact should be so stated above.