

No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 429851
Registrar's No. 2654

JAN 9 1942

Registration District No. 78X

Primary Registration District No. 200

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 year 26 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Katie B. Barnes

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

4. Sex F 3. 5. Color or race Colored 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 2 23 - 1925
(Month) (Day) (Year)

8. AGE: Years 16 Months 9 Days 28 If less than one day hr. _____ min. _____

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

10. Usual occupation School Girl

11. Industry or business _____

12. Name Luther Barnes

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

14. Maiden name Katie Thompson

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

16. (a) Informant Robert Koch Hospital Records

(b) Address Koch, Mo.

17. (a) _____ (b) Date thereof 12-31-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director E. J. Smith

(b) Address 424 N. E. 10th

19. (a) DEC 29 1941 (Date received local registrar) (b) E. J. Smith (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 14
(d) Street No. 2310 Eugenie (If rural, give location) 9
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 26
year 1941 hour 6 minute 40 P. M.

21. I hereby certify that I attended the deceased from 11
30 1940 to 12-26 1941
that I last saw her alive on 12-26 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____
Due to 13/1

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

Major findings: Of operations _____

Of autopsy _____

Duration

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) _____
(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 _____

23. Signature William Stumbo (M. D. or other) 0

Address Robert Koch Hospital Date signed 12/27/41

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

MOTHER FATHER

7111

(Licensed Embalmer's Statement on Reverse Side)

JAN 28 1942

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.....

William C. McDowell..... Registered Apprentice No.....
working under my personal supervision.

Signed William C. McDowell.....

Licensed Embalmer No. 2114.....

P. O. Address.....

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.