V. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

20033

State File No.

FILED AUG 21 1944

Registration District No. 318

Primary Registration District No. L 1003

Registrar's No. 7011

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

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: ST. JOHNS HOSP. O (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 DAY (Specify whether
In this community 5 Y/R. years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State MISSOURI (b) County 17
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 9
(d) Street No. 6429 WADE AVE. (If rural, give location) 4
(e) Citizen of foreign country? (Yes or No)
If yes, name country O

3. (a) PRINT FULL NAME OLIVIA BARRETT
3. (b) If veteran, name war NONE
3. (c) Social Security No. NONE
4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWE
6. (b) Name of husband or wife WILLIAM BERRETT
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased MAY (Month) 18 (Day) 1897 (Year)

8. AGE: Years 47 Months 2 Days 23 If less than one day hr. min.

9. Birthplace MT VERNON (City, town, or county) ILL (State or foreign country)
10. Usual occupation HOUSE WIFE
11. Industry or business
MOTHER FATHER
12. Name U/N KNOWN
13. Birthplace (City, town, or county) ILL (State or foreign country)
14. Maiden name U/N KNOWN
15. Birthplace (City, town, or county) ILL (State or foreign country)
16. (a) Informant Donald Barrett
(b) Address 6429 WADE AVE
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 12-1944 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEM.
18. (a) Signature of funeral director Friedrich F. Horne
(b) Address 8319 Halls Ferry Rd.
19. (a) AUG 11 1944 (Date received local registrar) (b) J. F. Brecheen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG. day 10 year 1944 hour 4 minute 30 A. M.
21. I hereby certify that I attended the deceased from Jan. 6, 1943 to August 10, 1944, that I last saw h. alive on August 9, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Generalized abdominal carcinomatosis — Duration 2 yrs.
Due to Carcinoma of Stomach — 4½ yrs
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)
(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 Charles Montani (M. D. or other) MD
Address 5147 Daggett ave Date signed 8-10-44

944 (Licensed Embalmer's Statement on Reverse Side)

## 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 By W Wilkinson

Licensed Embalmer No. 3575

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.**