

FILED AUG 28 1944

Registration District No. 31723

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063

State File No. 28690

Registrar's No. 1750

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 hours
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Barnes, Baby Boy

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

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased July 8 1944
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name Garland Barnes
13. Birthplace Webster Groves Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Delores Burgess
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Garland Barnes father

(b) Address 270 E. Kirkham

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-22-44
(Month) (Day) (Year)

(c) Place: burial or cremation No. Crematory

18. (a) Signature of funeral director St. Louis Co. Hosp.

(b) Address 651 Brentwood Blvd.

19. (a) AUG 28 1944 (Date received local registrar) (b) C. D. McShane (Registering a signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
(d) Street No. 270 E. Kirkham
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1944 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from July 8 (3:00) 1944 to July 8 (12:15) 1944; that I last saw him alive on July 8, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration 9 hours

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy 159

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 _____

Signature Milton A. Spitz (M. D. or other) _____

Address St. Louis County Hospital Date signed 8/22/44

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.....

Licensed Embalmer No.....

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.