

FILED NOV 22 1944

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 35636
Registrar's No. 9685

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: 3825 Windsor Pl
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 1 years, months or days

3. (a) PRINT FULL NAME Gwendoline Roberts Barrett

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James R. Barrett 6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased Dec. 11 1922
(Month) (Day) (Year)

8. AGE: Years 21 Months 11 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Clinton Roberts
13. Birthplace Louisiana
(City, town, or county) (State or foreign country)

{ 14. Maiden name Carrie Buckingham
15. Birthplace Lee County Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant James P. Barrett
(b) Address 3825 Windsor Pl

17. (a) Burial (b) Date thereof Nov. 15 '44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cem.

18. (a) Signature of funeral director Russell Untd. Co.
(b) Address 2732 Pine St.

19. (a) NOV 15 1944 (Date received local registrar)
J. F. Bredock (Registrar's signature)

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. 3825 Windsor Pl (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11
year 1944 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from Nov 4 1944 to Nov 11 1944
that I last saw h. er alive on Nov 11 1944
and that death occurred on the date and hour stated above

Immediate cause of death Pulmonary Tuberculosis Duration 5 Years

Due to _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Paul Thomsen (M. D. or other)
Address 539 N Grand Date signed Nov 15 1944

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

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

Jack Russell

Licensed Embalmer No. *4112*

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.