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S. No. 2  
2-2-45  
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I X35697DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

SEP 1 1945 318

Primary Registration District No. 1003

Registrar's No. 7387

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

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis City Hospital—Max C. Starkloff  
(If not in hospital or institution, write street number or location) Memorial  
 (d) Length of stay: In hospital or institution 10 days  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

## 3. (a) PRINT FULL NAME

John Barnes3. (b) If veteran, name war \_\_\_\_\_  
Nil3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widower  
 6. (b) Name of husband or wife Lucy Barnes 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased March 31 1865  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>4</u>	<u>23</u>	hr. min.

9. Birthplace St. James Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name William Barnes  
 13. Birthplace St. James Missouri  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Oliver Barnes  
(b) Address 3915 Magnolia Ave.

17. (a) Burial (b) Date thereof 8-26-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St. James, Missouri

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.19. (a) AUG 24 1945 (b) J. Prudel  
(Date received local health officer) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Phelps <sup>81</sup>  
 (c) City or town St. James <sup>3</sup>  
(If outside city or town limits, write "RURAL")  
 Street No. \_\_\_\_\_ (If rural, give location) <sup>0 NR</sup>  
 (e) Citizen of foreign country? ! (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 24th  
year 1945 hour 5:20 minute 14 M.21. I hereby certify that I attended the deceased from 8/14/45  
\_\_\_\_\_, 19\_\_\_\_, to 8/24/45, 19\_\_\_\_;  
that I last saw him alive on 8/24/45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.Immediate cause of death Carcinoma of Stomach  
Duration \_\_\_\_\_Due to \_\_\_\_\_  
Due to \_\_\_\_\_Other conditions Generalized Arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Same  
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 Herbert C. Fritz (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette <sup>8/24/45</sup>  
Date signed \_\_\_\_\_

**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 *Oliver R. Padwell*  
Licensed Embalmer No. *4977*  
P. O. Address *St. Louis*

**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.**