

Registration District No. 120

Primary Registration District No. 5451

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Miller Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 MONTHS (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Miss Aletha Gale Barnes

3. (b) If veteran, name war V 3. (c) Social Security No. NONE

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 1898 years
7. Birth date of deceased Jan 17 (Month) (Day) (Year)

8. AGE: Years 47 Months 6 Days 8 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name Joseph H. Barnes

13. Birthplace Quincy, MO (City, town, or county) (State or foreign country)

14. Maiden name Barnes

15. Birthplace Quincy, MO (City, town, or county) (State or foreign country)

16. (a) Informant Miss Henry Barnes

(b) Address St. Louis, MO

17. (a) (Burial, cremation, or removal) St. Louis, MO (b) Date thereof 12-27-45 (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, MO

18. (a) Signature of funeral director John H. Phillips

(b) Address St. Louis, MO

19. Dec 27 1945 (Date received local registrar) (b) John H. Phillips (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. None (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20 year 1945 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from 12/12/45 to 12/20/45 that I last saw her alive on 12/20/45 and that death occurred on the date and hour stated above.

Immediate cause of death Labor Pneumonia

Due to TYPE 4

Due to V

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 108

Of autopsy V

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) V

(b) Date of occurrence V

(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? V (Specify type of place) (e) Means of injury V

23. Signature C. H. Williamson (M.D. or other) 00

Address St. Louis, MO Date signed 12/27/45

RECEIVED
District Health Officer No. 11,
District File Number _____
Date Filed _____

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.