. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42838

FILED DEC 22 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11305

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 3920 LAFAYETTE AVE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution / (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County mo

(c) City or town ST LOUIS 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3920 LAFAYETTE AVE
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) O
If yes, name country

3. (a) PRINT FULL NAME ANNIE A BARTER

3. (b) If veteran, name war

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birthdate of deceased SEPT (Month) 15 (Day) 1864 (Year)

8. AGE: Years	Months	Days	If less than one day
83	2	24	hr. min.

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

10. Usual occupation NONE

11. Industry or business AT HOME

MOTHER FATHER

12. Name WILLIAM D BARTER

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

14. Maiden name ALICE AHEARN

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

16. (a) Informant SOPHIE BARTER

(b) Address 3920 LAFAYETTE AVE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 11 1947 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director Wm J. Robert & Sons

(b) Address 1903 S Grand Ave

19. (a) DEC 10 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 9 year 1947 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from 6-24-47 at St Louis Hosp 11/15-Dec 5, 1947 to 19 ; that I last saw h.er alive on Dec 9 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tumor of Esophagus malignancy undetermined	over 2 mo
Due to decided inoperable at Penrose Hosp	
Due to	
Other conditions Cachexia (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause of 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 O

23. Signature John Gilgun MD (M. D. or other)

Address 1715 Ls 39 Ch Date signed 12-10-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 Ronald Yahnke

Licensed Embalmer No. 3917

P. O. Address St Louis Mo

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.