

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5934

318

1003

Registrar's No. 1319

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u>				b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS 1</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		d. STREET ADDRESS (If rural, give location) <u>4231 WASHINGTON AVE</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4231 WASHINGTON AVE</u>				d. STREET ADDRESS (If rural, give location) <u>4231 WASHINGTON AVE</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>LEO</u>			b. (Middle) <u>J.</u>			c. (Last) <u>BARTER</u>					
4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 9 1949</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>DIVORCED</u>		8. DATE OF BIRTH <u>MARCH 17-1878</u>			
9. AGE (In years: if under 1 year last birthday) <u>70</u>		10. MONTHS <u>10</u>		11. DAYS <u>22</u>		12. HOURS _____		13. MIN. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER-OWN</u>			11. BIRTHPLACE (State or foreign country) <u>ST LOUIS MO</u>			12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME <u>WILLIAM D BARTER</u>			13b. MOTHER'S MAIDEN NAME <u>HONORA GAFFNEY</u>			14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>499-12-3961</u>		17. INFORMANT'S SIGNATURE OR NAME <u>SOPHIE BARTER</u>			ADDRESS <u>3920 LAFAYETTE</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>  ANTECEDENT CAUSES <u>Coronary Sclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				9/4a							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>W/O</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____		(COUNTY) _____		(STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____							
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:45A</u> m., from the causes and on the date stated above.											
23. SIGNATURE (Degree or title) <u>Patrick E. Taylor Coroner</u>				23b. ADDRESS <u>1300 Clark</u>			23c. DATE SIGNED <u>2-11-49</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>FEB 12-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>					
DATE REC'D BY LOCAL REG. <u>FEB 11 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Hasater</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm J. Robert Lively &amp; Sons 1905 S Grand</u>						

(Licensed Embalmers' Statement of Reverse Side)

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

No. 300  
10-48

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Ronald Yalunke

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3917

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.