S. No. 300
v. 10-48

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9781
2555

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

16

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3521 A. Arkansas

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 3521 A. Arkansas

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Alice Barry

4. DATE OF DEATH (Month) (Day) (Year): Mch. 21 1949

5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Feb. 15 1857
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Robertson Co. Tennessee
12. CITIZEN OF WHAT COUNTRY?: U.S

13a. FATHER'S NAME: not known
13b. MOTHER'S MAIDEN NAME: not known
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Homer D. Barry 3521 A. Arkansas

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Mitral Heart Disease — 3 years
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: none
410X
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1946, *to* March 21, 1949, *that I last saw the deceased alive on* March 20, 1949, *and that death occurred at* 1:10 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. Phil Lardenheuer MD
23b. ADDRESS: 3903 Olive St
23c. DATE SIGNED: 3/21/49

24a. BURIAL, CREMATION, REMOVAL (Specify): removal
24b. DATE: Mch. 22 1949
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Marion Kentucky

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE: MAR 21 1949 — J. B. Lawater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wm. Schumacher 3013 Meramec St. Louis

(Licensed Embalmer's Statement on Reverse Side)

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 Jack Haupt, Student Embalmer No. 231, working under my personal supervision.

Signed Jack Haupt
Student Embalmer

Signed Francis Williamson

Licensed Embalmer No. 3565

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.