

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

8524

No. 300
10-48

FILED OCT 13 1949

318

1003

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 ILLINOIS b. COUNTY Pike	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) 999 OR TOWN PITTSFIELD 11	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital, 6		d. STREET ADDRESS (If rural, give location) W.R., 111 FAYETTE	

3. NAME OF DECEASED (Type or Print)	a. (First) DOROTHY	b. (Middle) BLIE	c. (Last) BARBER	4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 5, 1949
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 26, 1904	9. AGE (In years last birthday) 44	10. IF UNDER 1 YEAR Months	11. IF UNDER 4 HRS. Hours	12. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Wagner, So. Dakota	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Harry V. Dailey	13b. MOTHER'S MAIDEN NAME Sarah Dailey	14. NAME OF HUSBAND OR WIFE Buford W. Barber
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Buford Barber, Pittsfield, Ill.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Suppur Erythematous Dermatitis</u> 2/24/49		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause, (a) stating the underlying cause last. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 153
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 70574
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22. I hereby certify that I attended the deceased from Oct. 1, 1949, to Oct. 5, 1949, that I last saw the deceased alive on Oct. 5, 1949, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ralph W. Forester M.D.	23b. ADDRESS Barnes Hospital.	23c. DATE SIGNED Oct. 5, 49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-6-49	24c. NAME OF CEMETERY OR CREMATORY West	24d. LOCATION (City, town, or county) (State) Pittsfield, Ill.
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DATE REC'D BY LOCAL REG. OCT 6 1949	REGISTRAR'S SIGNATURE J. B. Forester	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.
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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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Gay W. Wilkinson

Licensed Embalmer No.

3575

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.