

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34566

State File No.

FILED OCT 18 1950

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8322

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					
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) OR TOWN St. Louis					
d. FULL NAME OF HOSPITAL OR INSTITUTION Route 1 Hospital #1				7. STREET ADDRESS (If rural, give location) 5917 Thekla Avenue					
3. NAME OF DECEASED (Type or Print) Winifred		a. (First)		b. (Middle) F.		c. (Last) Barnett			
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		4. DATE OF DEATH (Month) (Day) (Year) Oct. 1, 1950			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH February 1, 1898		9. AGE (In years last birthday) 52			
11. BIRTHPLACE (State or foreign country) New Jersey				12. CITIZEN OF WHAT COUNTRY? USA					
13a. FATHER'S NAME Alvah E. Innes		13b. MOTHER'S MAIDEN NAME Rodessa E. Poole		14. NAME OF HUSBAND OR WIFE William V. Barnett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. William V. Barnett, 5917 Thekla Ave.					
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				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)				ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) Cerebellar Apoplexy					
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"/>			
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? 334					
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 10:23 P.M. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Dorothy E. Taylor				23b. ADDRESS 1300 Clark Ave		23c. DATE SIGNED 10/3/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE October 1, 1950		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
DATE REC'D BY LOCAL REG. OCT 3 1950		REGISTRAR'S SIGNATURE J. B. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Ave.					

(Licensed Embalmer's Statement on Reverse Side)

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

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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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Homer H. Dritz

Signed.....

Student Embalmer

Licensed Embalmer No. *3882*

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.