

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2336**
146
Registrar's No.

FILED JAN 19 1951

BIRTH NO. **42880-50** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.	c. LENGTH OF STAY (In this place) 1 da	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Vichy	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital		d. STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED (Type or Print)	a. (First) JUDY	b. (Middle) KRY	c. (Last) BARNES	4. DATE OF DEATH (Month) (Day) (Year) 1 - 7 - 51
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 7-19-50	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 5	IF UNDER 1 YEAR Days 18	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Waynesville, Mo	12. CITIZEN OF WHAT COUNTRY? American
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13a. FATHER'S NAME Robert Barnes	13b. MOTHER'S MAIDEN NAME Hazel DeShaney	14. NAME OF HUSBAND OR WIFE -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME G. Carson	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 24 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Laryngeal tracheal bronchitis		5 mo. 18 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congenital heart disease type undetermined 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 1-6-51	19b. MAJOR FINDINGS OF OPERATION Tracheotomy	20. AUTOPSY? YES <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 75 ft. H
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22. I hereby certify that I attended the deceased from **1-6**, 19**51**, to **1-7**, 19**51**, that I last saw the deceased alive on **1-7**, 19**51**, and that death occurred at **6:50 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Wm. Klingberg MD	(Degree or title) MD	23b. ADDRESS Childrens Hospital	23c. DATE SIGNED 1-7-1951
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 1-7-1951	24c. NAME OF CEMETERY OR CREMATORY 1	24d. LOCATION (City, town, or county) (State) Vichy Mo
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DATE REC'D BY LOCAL REG. JAN 8 1951	REGISTRAR'S SIGNATURE J. B. Casater	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.	ADDRESS
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WRITE PLAINLY—USING UNEADING 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.....

Ronald Dyckstra

Signed.....

Student Embalmer

Licensed Embalmer No. *3917*

P. O. Address *Theris 10 M*

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.