

FILED MAY 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17797
4362

BIRTH NO. _____ REG. DIST. NO. 218 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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 OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2269	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 1439 Chambers St. 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			

3. NAME OF DECEASED (Type or Print) a. (First) EDNA	b. (Middle) Ann	c. (Last) BARNES	4. DATE OF DEATH (Month) (Day) (Year) MAY 7 1951
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Dec. 9-1931	9. AGE (in years last birthday) 19	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Training School	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri 0	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Edward Barnes	13b. MOTHER'S MAIDEN NAME Reda Grimes	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. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert Grines 1439 Chambers St
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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>Pneumonia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>probably due to metastasis</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Long-standing syphilis</u>			

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)
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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? <u>2nd floor</u>
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22. I hereby certify that I attended the deceased from 4-26-51, 1951, to 5-7-51, 1951, that I last saw the deceased alive on 5-7-51, 1951, and that death occurred at 4:20P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>R. Kiyam M.D.</u>	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 5-8-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 9-51	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. MAY 9 1951	REGISTRAR'S SIGNATURE <u>J. B. Pasater</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leidner U., 2223 St. Louis Ave.
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *John P. Buchholz*

Licensed Embalmer No. *1674*

P. O. Address *3223 S. Ocean Ave.*

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.