

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38674

DEC 15 1951

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1003

State File No. _____

Registrar's No. 10898

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		c. CITY (If outside corporate limits, write RURAL and give township) 1003 TOWN St. Louis, Mo. 2189	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 521 S Ewing	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH
a. (First) James			(Month) (Day) (Year) Dec. 6 1951
b. (Middle) Barnes			
c. (Last) Barnes			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 28, 1881
9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Mississippi
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Foundry	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Joseph Barnes		13b. MOTHER'S MAIDEN NAME Margaret Rhodes	14. NAME OF HUSBAND OR WIFE Virginia Barnes
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. 497-01-4945	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Eugene Barnes (son) 521 S. Ewing
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) : Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH Undet.
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
DUE TO (b) Undetermined			
DUE TO (c) None			
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 type="checkbox"/> NO <input checked="" 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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H 200	
22. I hereby certify that I attended the deceased from 10-31, 1951, to 12-6, 1951, that I last saw the deceased alive on 12-6, 1951, and that death occurred at 11 a. m., from the causes and on the date stated above.			
23a. SIGNATURE Frank O. Richard M.D.		23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 12-7-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-12-'51	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
DATE REC'D BY LOCAL REG. DEC 10 1951	REGISTRAR'S SIGNATURE Paul Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Riley Undertakers-3759 Finney Ave.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING 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 _____

Lawrence Woodrow

Licensed Embalmer No. _____

4341

P. O. Address _____

St Louis 13, 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.