

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30567

XC-1 994 013
Reg. 10921 SL-7142

State File No.

BIRTH NO. FILED OCT 7 - 1955 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8531

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY Warren	
b. CITY OR TOWN 915 N. Grand, St. Louis, Mo.	c. LENGTH OF STAY (In this place) 20 days	c. CITY OR TOWN WARRENTON	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hosp.		e. STREET ADDRESS (If rural, give location) Route #2, Box 151	

3. NAME OF DECEASED (Type or Print) a. (First) Robert	b. (Middle) E.	c. (Last) BARR	4. DATE OF DEATH (Month) (Day) (Year) 9-28-55
---	-------------------	-------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-15-89	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 14 HRS. Hours	IF UNDER 1 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Charles Barr	13b. MOTHER'S MAIDEN NAME Francis Lee	14. NAME OF HUSBAND OR WIFE Anna Barr
------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME VA Hosp. Records, 915 N. Grand, St. Louis, Mo.	ADDRESS
--	------------------------------------	---	---------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 36 Hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocardial Infarction</u>		
	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. <u>Hepatic Fibrosis Uremia</u>		

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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from 9-8-55, 1955, to 9-28-55, 1955, that his death was caused by Acute Myocardial Infarction, and that death occurred at 2:40 p. m., from the causes and on the date stated above.

23a. SIGNATURE D. G. ROMER	(Signature or title)	23b. ADDRESS M.D. VAH, 915 N. Grand, St. Louis, Mo.	23c. DATE SIGNED 9-28-55
-------------------------------	----------------------	--	-----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-28-55	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Warrenton Mo
--	----------------------	------------------------------------	---

DATE REC'D BY LOCAL REG. SEP 29 1955	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
---	---	---	----------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.40

OCT 20 1954

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 Signature of Student Embalmer

Signed *[Handwritten Signature]* Licensed Embalmer No. P. O. Address *[Handwritten Address]*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.