FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 6222

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 827

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Length of stay in lb 04

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 5757 Westminster Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First BARNEY Middle W. Last GOLBART

4. DATE OF DEATH Month Day Year JAN. 25, 1957

5. SEX Male 0
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) Abt. 62 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer
10b. KIND OF BUSINESS OR INDUSTRY Dress
11. BIRTHPLACE (City and state or country) Russia 6
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Isaac Golbart
14. MOTHER'S MAIDEN NAME Maltze Silberman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Address Norman Golbart-5757 Westminster

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH SEV. HRS.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CORONARY ARTERIOSCLEROSIS — SEV. YRS.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from JAN. 16, 1957, to JAN. 25, 1957 and last saw her/him alive on JAN. 25, 1957
Death occurred at 6:40 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) O Robert L. Lam M.D. 0
22b. ADDRESS BARNES HOSPITAL
22c. DATE SIGNED 1/26/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 1/27/57
23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.
23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS Herman Rindskopf, Inc. 5216 Delmar
25. DATE RECD. BY LOCAL REG. JAN 26 '57
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 0
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 38

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.