

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25923

FILED JUL 16 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6108**

STATE FILE NUMBER

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN Affton | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital | | d. STREET ADDRESS (If outside, give location) 9301 Niles Pl. | |
| Length of stay in 1b 3 Weeks | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CHARLES BOWLING BARRON | | | 4. DATE OF DEATH Month Day Year 6-29-1957 |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-4-1880 |
| 9. AGE (In years last birthday) 76 7/7 | | 10. IF UNDER 1 YEAR OF UNDER 24 HRS. Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grain Supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | |
| 11. BIRTHPLACE (City and state or country) Columbia Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jacob Barron | | 14. MOTHER'S MAIDEN NAME Susan Gooch | |
| 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. None | |
| 17. INFORMANT Mrs. C. B. Barron | | Address 9301 Niles Pl. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic carcinomatosis <i>Hepatic Carcinomatosis They regarded Failure - Arteriosclerotic Heart Myocardial failure arteriosclerotic heart Carcinoma of prostate</i> carcinoma of prostate DUE TO (b) 177X DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) | | | INTERVAL BETWEEN ONSET AND DEATH 3 months 1 year 8 yrs |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2 | |
| 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Hour . Month, Day, Year a. m. p. m. | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION 1010 6-29-57 | | COUNTY STATE 6-29-57 | |
| 21. I attended the deceased from 7:49 P.M. 6-29-57 and last saw her alive on 6/29/57 Death occurred at 4:40 P.M. on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Morris Herman M.D. | | 22b. ADDRESS 3701 Grandel Sq. | |
| 22c. DATE SIGNED 7/1/57 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 7-2-1957 | |
| 23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. | |
| 24. FUNERAL DIRECTOR Parker-aldrich White Groves Mo. | | 25. DATE RECD. BY LOCAL REG. 1-57 | |
| 26. REGISTRAR'S SIGNATURE Carl Smith M.D. | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION BY *Dr. J. J. ...*

JUL 25 1957

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 *Lucille Welch*.....

Licensed Embalmer No. *43*

P. O. Address *Abster*.....

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.