Health, & Welfare Public Service

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1-57

FILED OCT 14 1957

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

33195

STATE FILE NUMBER 8872

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hospital #1 — Length of stay in lb 25
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) 4248 Flad Ave. — Reside on Farm Yes ☐ No ☐
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3. NAME OF DECEASED (Type or print) First Eliza Lyda Middle Last Barker
4. DATE OF DEATH Month Day Year September 20, 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar. 18-1889
9. AGE (In years last birthday) 68 — 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) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY At. Home
11. BIRTHPLACE (City and state or country) Marshall, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 498-34-6617
17. INFORMANT Mrs. A. Hook Address 4248 Flad Ave.

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) Rupture of Esophagus & Stomach — INTERVAL BETWEEN ONSET AND DEATH 24 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) extreme vomiting
DUE TO (c) Mallory-Weiss Syndrome
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
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 9-6-57, to 9-20-57 and last saw her alive on 9-20-57
Death occurred at 12:00 Midnight m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John C Doubek Jr M.D.
22b. ADDRESS 1515 Lafayette
22c. DATE SIGNED 9-22-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 6-24-1957
23c. NAME OF CEMETERY OR CREMATORY St. Matthew Cemetery
23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR Bull-Campbell ADDRESS 5165 Delmar Blvd.
25. DATE RECD. BY LOCAL REG. SEP 23 57
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. G.P.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
additional from letter City Hosp. - Wrote Jeff City for Classification

## 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 ..... Signed Elmer Cadwell

Signature of Student Embalmer

Licensed Embalmer No. 4977

P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.