

Health, Welfare, Public Service

300 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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

33198

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. _____ Registrar's No. **8298**

| | | | | | |
|---|-------------------------------|---|---|---|---|
| 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, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR 27 INSTITUTION Homer G. Phillips | | Length of stay in lb | d. STREET ADDRESS 2207 S 2231a Cass (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Jessica Middle Cecila Last Barney | | | 4. DATE OF DEATH Month 7 Day 4 Year 57 | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-4-57 | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Julius C. Barney | | | 14. MOTHER'S MAIDEN NAME Roberta Susix | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mary E Jett Address R.R.L. 2601 Whittier St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Atelectasis | | | | | INTERVAL BETWEEN ONSET AND DEATH undet. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 762.5 | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 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 COUNTY STATE | |
| 21. I attended the deceased from 7-4-57 to 7-4-57 and last saw her alive on 7-4-57 Death occurred at 6:05 P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE William N. Snickles M.D. (Degree or title) | | | 22b. ADDRESS 2601 Whittier Street | | 22c. DATE SIGNED 8-27-57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 9-30-57 | | 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | |
| | | | | 23d. LOCATION (City, town, or county) (State) St. Louis, Mo. | |
| 24. FUNERAL DIRECTOR Rowland Sker ADDRESS 4104 Manchester | | | 25. DATE RECD. BY LOCAL REG. SEP 5 '57 | | 26. REGISTRAR'S SIGNATURE Cash Smith |

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.....

Licensed Embalmer No.....

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.