

t. Health,  
s. Welfare  
s. Public  
th Service

FILED NOV 15 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37145

STATE FILE NUMBER 10636

318

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>6408 Oakland</b>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <b>SARAH JOSEPHINE BARCLAY</b>			4. DATE OF DEATH Month Day Year <b>November 7, 1957</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12, 1870</b>	9. AGE (In years last birthday) <b>86</b>	FUNDER 1 YEAR Months <b>11</b> Days <b>25</b>	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Mendon, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Preston Asher</b>	13b. MOTHER'S MAIDEN NAME <b>Mary A. Francis</b>	14. NAME OF HUSBAND OR WIFE <b>Benn N. Barclay</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Kathryn Barclay 6408 Oakland</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.	DUE TO (b) <b>Art. Sclerosis</b>	<b>years</b>
	DUE TO (c) <b>Hypertensive Vascular Disease</b>	<b>years</b>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) <b>443X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from <b>10/16/57</b> to <b>Nov. 7, 1957</b> and last saw <sup>her</sup> <del>him</del> alive on <b>Nov. 7, 1957</b> Death occurred at <b>5:00 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>Arthur E. Stroud M.D.</b>	22b. ADDRESS <b>539 N. Grand</b>	22c. DATE SIGNED <b>11/8/57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Nov. 11, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Linneus, Missouri</b>
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24. FUNERAL DIRECTOR <b>Ambruster Mortuary, 6633 Clayton Rd.</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 8 '57</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

S.P.

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 *Frederick J. Turner*  
Licensed Embalmer No. *4788*  
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.