

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015509
STATE FILE NUMBER

FILED APR 28 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3889**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Berkeley 4091	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hosp.		d. STREET ADDRESS (If outside, give location) 8621 Scudder Av.	
3. NAME OF DECEASED (Type or print) Langdon Scott Barron Sr.		4. DATE OF DEATH Month 4 Day 6 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Alpha Brass Co.	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
13a. FATHER'S NAME Langdon C. Barron		13b. MOTHER'S MAIDEN NAME Ida Reeder	14. NAME OF HUSBAND OR WIFE Clara A. Barron
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. 494-36-9326	17. INFORMANT Address Clara A. Barron 8621 Scudder Av.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myelogenous leukemia			INTERVAL BETWEEN ONSET AND DEATH 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			2043
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK OR 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 1/30/58 to 4/6/58 and last saw him alive on 4/5/58 Death occurred at 2 a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. C. Hueblich MD (Degree or title) 0		22b. ADDRESS 111 Church St Ferguson	22c. DATE SIGNED 4/7/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/9/58	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR White-Mullen 118 N. Florissant Rd.		25. DATE RECD. BY LOCAL REG. APR 8 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. mjgib.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Eleanor Porvine

Licensed Embalmer No. 3403
P. O. Address Jennings

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.