

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-037579
 State File No.

FILED OCT 20 1958 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 93779

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. LENGTH OF STAY (in this place) 10 hours	
d. FULL NAME OF HOSPITAL OR INSTITUTION 09 DE PAUL HOSP.		e. STREET ADDRESS (If rural, give location) 27 910 N. LAFAYETTE	
3. NAME OF DECEASED (Type or Print) a. (First) BABY		b. (Middle) -	
c. (Last) BAREKMAN		4. DATE OF DEATH (Month) (Day) (Year) 9 27 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 9-27-58
9. AGE (In years last birthday)		10. UNDER 1 YEAR Months	11. UNDER 2 HRS. Hours Min. 10 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME GEORGE W. BAREKMAN		13b. MOTHER'S MAIDEN NAME BETTY JEAN BOOTH	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Betty Jean Barekman	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Polymenorrhea		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Erythema infectiosum			
DUE TO (c) Placenta previa			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		770.5	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-27-58, to 9-27-58, that I last saw the deceased alive on 9-27-58, and that death occurred at 4:25 P.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Fred. Leo M.D.		23b. ADDRESS 6000 W. Florissant	
23c. DATE SIGNED 9-29-58			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-28-58	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Marion, Ill.	
DATE REC'D BY LOCAL REG. SEP 30 '58		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mitchell, Marion, Illinois			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Harvey Kable*.....

Licensed Embalmer No. *4596*.....

P. O. Address *Elouissant*.....

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.