

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037582
STATE FILE NUMBER

33955 38
FILED OCT 23 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9754

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 INSTITUTION Cardinal Glennon Hosp			Length of stay in lb	d. STREET ADDRESS (If outside, give location) 3129 Cass Ave			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Shelby Middle R. Last Barnes				4. DATE OF DEATH Month Oct Day 12 Year 58			
5. SEX Male	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 May 17.58		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Shelby Barnes				14. MOTHER'S MAIDEN NAME BARBARA Brown			
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. No		17. INFORMANT Address Shelby Barnes 3129 Cass Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia; abscess							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Meningococci (repaired); Hydrocephalus				4 Mo.	
		DUE TO (c) Arnold-Chiari Syndrome					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 753.1							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
21. I attended the deceased from Sept. 1958 to Oct. 1958 and last saw him alive on 10-12-58 Death occurred at 7:15 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Edwin T. Davis M.D.				22b. ADDRESS Cardinal Glennon Hospital		22c. DATE SIGNED 10-13-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/14/58	23c. NAME OF CEMETERY OR CREMATORY Washington Park		23d. LOCATION (City, town, or county) (State) St. Louis County Mo			
24. FUNERAL DIRECTOR Boyd Bros			ADDRESS 3706 Finney Ave		25. DATE RECD. BY LOCAL REG. OCT 14 58	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Edward O Flynn*.....

Licensed Embalmer No. 4444

P. O. Address St. Louis..

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.