

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038471
STATE FILE NUMBER

FILED OCT 23 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2653

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| 1. PLACE OF DEATH a. COUNTY St. Louis 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, give TOWNSHIP only) OR TOWN Koch, Mo. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN City of St. Louis Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hospital Length of stay in 1b 73 days | | d. STREET ADDRESS (If outside, give location) 1012 S. 4th St Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|--|----------------------------------|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First John Middle - Last BARNABY | | | 4. DATE OF DEATH Month 10 Day 13 Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-23-70 | | 9. AGE (In years last birthday) 88 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Peddler | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (City and state or country) Illinois | | |
| 13. FATHER'S NAME William Barnaby | | | 14. MOTHER'S MAIDEN NAME Sarah Ann ?? | | | |
| 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. None | | 17. INFORMATION Address Records at Robert Koch Hospital | | |

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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) Arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH 12 yrs? |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Infarction; Chronic Pulm Fibrosis with Emphysema | | 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.) 4200 | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____ | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20f. CITY, TOWN, OR LOCATION COUNTY STATE _____ | |

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|---|---|
| 21. I attended the deceased from 8-1-58 to 10-13-58 and last saw ^{DEP} him alive on 10-13-58 Death occurred at 6:05 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE (Degree or title) Harold G. Russell M.D. | 22b. ADDRESS Robert Koch Hospital |
| 22c. DATE SIGNED 10-14-58 | |

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|---|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 10-15-58 | 23c. NAME OF CEMETERY OR CREMATORY St. Trinity | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS McLaughlin Funeral Home, Inc. 2301 Lafayette, St. Louis, Mo. | | 25. DATE RECD. BY LOCAL REG. 10-15-58 | 26. REGISTRAR'S SIGNATURE Herbert D. Donley, M.D. |

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service

300
1-56

vector, 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

MEDICAL CERTIFICATION

HW

STATE OF ILLINOIS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
DIVISION OF ANATOMY AND EMBALMING
CERTIFICATE OF EMBALMING

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 James R. Chapman
Licensed Embalmer No. 4
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.