URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS SEP 2 9 1959

59-033549

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8363

MENDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b

c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Homer G. Phillips Hosp. — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 5567 Wells — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Theresa Middle A.K.A. Phyliss Last Barry

4. DATE OF DEATH Month 9 Day 8 Year 59

5. SEX Female

6. COLOR OR RACE Negro

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 7/25/59

9. AGE (last birthday) 6 Weeks — IF UNDER 1 YEAR Months 1 Days 14 — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) St. Louis

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME Lonnie Barry

13b. MOTHER'S MAIDEN NAME Theresa Anderson

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Lonnie Barry Address 5567 Wells

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonitis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 492x

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 WORK ☐ NOT WHILE AT WORK ☐

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 _____, to _____ and last saw her/him alive on _____
Death occurred at 10:00A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M. Quinn Deputy Coron

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 9/9/59

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE 9/10/59

23c. NAME OF CEMETERY OR CREMATORY Washington Park

23d. LOCATION (City, town, or county) (State) St. Louis County Mo.

24. FUNERAL DIRECTOR T. Glenn & B. Walker ADDRESS 4319 Delmar

25. DATE RECD. BY LOCAL REG. SEP 10 '59

26. REGISTRAR'S SIGNATURE Karl Smith M.D. MOB

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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~~ NOT E

~~or~~ By NOT EMBALMED, Student Embalmer No.

working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.