

# FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-041527

FILED VS NOV 20 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **210393**

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b _____		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5183 Raymond</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Kathleen</b> Middle _____ Last <b>Barnes</b>				<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>1</b> Year <b>59</b>					
<b>5. SEX</b> <b>Fem.</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10-31-59</b>		<b>9. AGE (last birthday)</b> IF UNDER 1 YEAR: Months _____ Days <b>1</b> IF UNDER 24 HR: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) _____			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <b>Saint Louis, Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>		
<b>13a. FATHER'S NAME</b> _____			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Annie Bell Jones</b>			<b>14. NAME OF HUSBAND OR WIFE</b> _____			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____			<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <b>Hospital Records 2601 N. Whittier</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature birth</b>							INTERVAL BETWEEN ONSET AND DEATH _____		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Congenital Heart Disease</b>							_____		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____		_____					
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		COUNTY _____ STATE _____			
<b>21. I attended the deceased from</b> <b>10-31-59</b> to <b>11-1-59</b> and last saw <del>her</del> <sup>him</sup> alive on <b>11-1-59</b> Death occurred at <b>9:00 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							_____		
<b>22a. SIGNATURE</b> <i>Park White</i> (Degree or title) <b>M. D.</b>				<b>22b. ADDRESS</b> <b>2601 N. Whittier</b>			<b>22c. DATE SIGNED</b> <b>11-3-59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) _____		<b>23b. DATE</b> <b>11-30-59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Anatomical Board</b>		<b>23d. LOCATION</b> (City, town, County) (State) <b>St. Louis, Mo.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Rowland Mortuary Svc. 4104-06 Manchester</b> ADDRESS _____				<b>25. DATE RECD. BY LOCAL REG.</b> <b>NOV 12 1959</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>Neal Smith M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*21. 8.03*

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.