

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031848

FILED VS SEP 2 1960 318

Primary Registration District No. 1003

Registrar's No. 7890

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>St Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Length of stay in 1b	c. CITY OR TOWN <u>MEHLVILLE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST ANTHONY HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3646 ANITA LA.</u>	
3. NAME OF DECEASED (Type or print) First <u>DEWEY</u> Middle <u>EDWIN</u> Last <u>BARBER</u>			4. DATE OF DEATH Month <u>AUG</u> - Day <u>8</u> - Year <u>1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-4-1902</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOVEL OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ALPHA PORTLAND CEMENT CO</u>		11. BIRTHPLACE (City and state or country) <u>OHIO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>ARTHUR BARBER</u>		13b. MOTHER'S MAIDEN NAME <u>RITA SIMPSON</u>		14. NAME OF HUSBAND OR WIFE <u>LEONA BARBER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>488-01-3556</u>		17. INFORMANT <u>LEONA BARBER</u> Address <u>3646 ANITA LA ST LOUIS 26 MO</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LYMPHATIC LEUKEMIA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS -</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>2040</u>					
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 _____ STATE _____
21. I attended the deceased from <u>10/16/59</u> to <u>8/8/60</u> and last saw him alive on <u>8/8/60</u> Death occurred at <u>8:30 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>D Benjamin MD</u> (Degree or title)			22b. ADDRESS <u>7430 Virginia Ave</u>		22c. DATE SIGNED <u>8/10/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>AUG-11-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT Hope Cem</u>		23d. LOCATION (City, town, or county) <u>LEMAU, MO</u> (State)	
24. FUNERAL DIRECTOR <u>Fey FUNERAL HOME, MEHLVILLE, MO</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>AUG 10 1960</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

701 82

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Robert J. Lee Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood

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