

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

1429-61-006204 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED VS FEB 28 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If outside, give location) 5817a Devonshire Ave	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL B. BARRON			4. DATE OF DEATH Month Day Year Feb. 12, 1961		
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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 8/23/11	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY Brokerage	11. BIRTHPLACE (City and state or country) St. Louis Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Abraham Barron	13b. MOTHER'S MAIDEN NAME Rose Heller	14. NAME OF HUSBAND OR WIFE *****
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Mrs. R. Barron 7418 Stanford	Address
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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) <u>renal failure</u> DUE TO (b) <u>Govt -</u> DUE TO (c) <u>pleural effusion. Accets.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>10+ years</u> <u>4-5 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>603.1</u>		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 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.)
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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
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21. I attended the deceased from <u>1950</u> to <u>1961</u> and last saw ^{him} alive on <u>11/16/61 at 10:00</u> Death occurred at <u>4 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Staves Freedman M.D.</u>	22b. ADDRESS <u>607 No. Grand St. St. Louis Mo</u>	22c. DATE SIGNED <u>2/17/61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE <u>2/13/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri</u>
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24. FUNERAL DIRECTOR HERMAN RINDSKOPF INC. 5216 DELMAR	25. DATE RECD. BY LOCAL REG. FEB 13 1961	26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u>
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AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 Peter P. Kubron, M.D.

Licensed Embalmer No. 3691

P. O. Address St. Louis, Mo.

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.