

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4582**

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b	c. CITY OR TOWN E. St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1298 N. 71st St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CLEAVA Middle FERN Last BARGER			4. DATE OF DEATH Month MAY Day 15 Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widow <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-8-1909	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Chicken Farm	11. BIRTHPLACE (City and state or country) Alton, Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Henry William Wagoner		13b. MOTHER'S MAIDEN NAME Anna Elizabeth Tryon		14. NAME OF HUSBAND OR WIFE E. John Barger (dec'd)	
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. INFORMANT St. Louis, Ill. Mrs. Oliver Starks 6901 Rock Springs	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) PULMONARY EDEMA					FEW HOURS
DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE					5 YEARS
DUE TO (c) 443x					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC GLOMERULONEPHRITIS					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
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 APRIL 28, 1961 to MAY 15, 1961 and last saw her/him alive on MAY 15, 1961 Death occurred at 12:35 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) C. G. Kurrus, Jr. M. D.			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 5/15/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-17-61	23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Gardens		23d. LOCATION (City, town, or county) (State) Belleville Illinois	
24. FUNERAL DIRECTOR C. G. Kurrus, Jr.		ADDRESS E. St. Louis, Illinois		25. DATE RECD. BY LOCAL REG. MAY 15 1961	26. REGISTRAR'S SIGNATURE Loard Smith, M. D.

STATE OF TEXAS

STATEMENT BY LICENSED EMBALMER

FRANKLIN D. BROWN

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.

Not embalmed
Signed *Chas. J. Ferrus*

Student _____
Signature of Student Embalmer

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.