

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042184

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

10774

STATE FILE NUMBER

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

FILED NOV 28 1961

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. 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 <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4041 Connecticut St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JANE Middle Last BARRETT			4. DATE OF DEATH Month Nov. Day 19 Year 1961		
5. SEX Female	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 9-8-1880	9. AGE (last birthday) 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Attendant-City		10b. KIND OF BUSINESS OR INDUSTRY Hospital(Retired)		11. BIRTHPLACE (City and state or country) Catawissa, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John T. Barrett		13b. MOTHER'S MAIDEN NAME Catherine A. Brennan		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			17. INFORMANT Address Thomas Barrett 3927 Chippewa St.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess, lung, left upper		INTERVAL BETWEEN ONSET AND DEATH Several weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) 521x	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arterio sclerotic heart diseased with pleural effusion.		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 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.)	
---	---	---	--

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 **11-9-61** to **11-19-61** and last saw her/him alive on **11-19-61**
Death occurred at **10:30 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Clement S. Sweeney (Degree or title) M.D.	22b. ADDRESS 4161 Lindell St. Louis.	22c. DATE SIGNED 11-20-61
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 22, 1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo.
--	-----------------------------------	---	--

24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.	25. DATE RECD. BY LOCAL REG. NOV 20 1961	26. REGISTRAR'S SIGNATURE Roald Smith, M.D.
--	--	---

DATE AWIENCED
INDICATED BY
SHOULD READ
ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

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 *Neil P. [Signature]*
Student Embalmer No. _____

Licensed Embalmer No. 4533
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.