

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-020156
5404 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED JUN 5 1962

VS 300
Rev. 4/59
1
2 <u>220</u>
3
4 <u>1</u>
5 <u>2</u>
6
7 <u>0</u>
8 <u>2</u>
9
10
11
12 <u>90-0</u>
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATE

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>ST. LOUIS</u>		Length of stay in 1b <u>2 YRS.</u>	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3323 So. Jefferson</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3323 So. Jefferson</u>

3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>-</u> Last <u>BARR</u>			4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>62</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1892</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>CAPE GIRARDEAU, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>CHARLES DUEKER</u>	13b. MOTHER'S MAIDEN NAME <u>ROSA WAHL</u>	14. NAME OF HUSBAND OR WIFE <u>RAYMOND ARTHUR BARR</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>UNKNOWN</u>	17. INFORMANT <u>FRED STAMM</u>	Address <u>4459 CANNETT ST. LOUIS</u>
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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>Cerebral vascular accident</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Several</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	DUE TO (c)
		<u>331X</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Essential Hypertension, Diabetes Mellitus</u>	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 8-19-59 to 5-28-62 and last saw her live on 3-21-62
Death occurred at about 3:00 pm m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Thos. J. Barr</u>	22b. ADDRESS <u>35 No Central Clayton St. Mo.</u>	22c. DATE SIGNED <u>5-29-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-5-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LARMIER Cem.</u>	23d. LOCATION (City, town, or county) <u>CAPE GIRARDEAU MO</u>
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24. FUNERAL DIRECTOR <u>HAMAN</u>	ADDRESS <u>CAPE GIRARDEAU MO</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 29 1962</u>	26. REGISTRAR'S SIGNATURE <u>Roal Smith M.D.</u>
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USE BLACK INK OR TYPEWRITER RIBBON

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

Frank Prohaff

Licensed Embalmer No.

4356

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.