

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

663-041040

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 306 Primary Registration District No. 6048 Registrar's No. 46

FILED OCT 18 1963

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Charles | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Charles | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN O'Fallon | | c. CITY OR TOWN O'Fallon | |
| Length of stay in 1b 16 yrs | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 318 Pitman | | d. STREET ADDRESS (If outside, give location) 318 Pitman | |
| 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) Arthur H. Barclay | | 4. DATE OF DEATH Month Oct. Day 12 Year 1963 | |
| 5. SEX male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12-7-1874 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Postal Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY US. Post Office | 9. AGE (last birthday) 88 |
| 11a. FATHER'S NAME William Barclay | | 11b. MOTHER'S MAIDEN NAME Annie Johnson | 11. BIRTHPLACE (City and state or country) Palmeroy, Ohio |
| 12. CITIZEN OF WHAT COUNTRY USA | | 14. NAME OF HUSBAND OR WIFE Kate (snider) Barclay | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Kate Barclay | |
| 17. INFORMANT Address O'Fallon, Mo | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiac insufficiency DUE TO (c) Arteriosclerotic Heart Disease | |
| 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 <input type="checkbox"/> s.m. <input type="checkbox"/> 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 11-10-62 to 10-12-63 and last saw him alive on 10-11-63 Death occurred at 11:12 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Albert C. Roeper D.O. | | 22b. ADDRESS 411 Farming St. O'Fallon, Mo. | |
| 22c. DATE SIGNED 10-14-63 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | |
| 23b. DATE Oct 15, 1963 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery | |
| 23d. LOCATION (City, town, or county) St. Louis, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR Keithly-Davis Funeral Home | | 25. DATE RECD. BY LOCAL REG. 10-16-63 | |
| ADDRESS O'Fallon, Mo | | 26. REGISTRAR'S SIGNATURE E. Keithly | |

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

OCT 29 1963

1840
1290

STATEMENT BY LICENSED EMBALMER

4-28

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 Jerry A. Davis

Licensed Embalmer No. 5139

P. O. Address Chillicothe, 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.