

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-049227**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **12220**

STATE FILE NUMBER

**FILED DEC 20 1963**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

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INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in lb <b>28yrs</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>2735 Mill Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DEALUS B. BARFIELD</b>		4. DATE OF DEATH Month Day Year <b>Dec 7 1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-5-1925</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <b>Memphis Tenn</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Dealus Barfield</b>		13b. MOTHER'S MAIDEN NAME <b>Georgia Coleman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Georgia Hill</b>		Address <b>2735 Mill Street</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hemorrhage; Contrib. Cause: Fracture of the Occipital region of the skull; following injuries suffered when car operated by the deceased went out of control and turned over, on Highway #67 in St. Francis County, Mo., about 6:15 P.M on Dec, 7th 1963.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Accident</b> 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 SUICIDE HOMICIDE <b>A</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>See above</b>		20c. TIME OF INJURY Hour Month, Day, Year <b>6:15 p.m. 12-7-63</b>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway 67</b>	
20f. CITY, TOWN, OR LOCATION <b>St. Francis County, Mo</b>		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>7:38 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Helen L. Taylor, Coroner</b>		22b. ADDRESS <b>1300 Clark Ave</b>	
22c. DATE SIGNED <b>12-10-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-13-1963</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>National</b>		23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks Mo</b>	
24. FUNERAL DIRECTOR <b>JAS H. RANDLE &amp; SON</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 10 1963</b>	
ADDRESS <b>3133 Bell Ave</b>		REGISTRAR'S SIGNATURE <b>Lois Smith, M.D.</b>	

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**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 *Ether N. Harris*

Licensed Embalmer No. 4458

P. O. Address 4181 Washington

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.