

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH

State File No. **13350**  
 Registrar's No. **3552**

Registration District No. **791** Primary Registration District No. **1003**

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: City Hospital, #1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 28 Days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Audry Barnes

8. (b) If veteran, name war No. 8. (c) Social Security No. 1652

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 28 1887  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
52 8 19 hr. min.

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business 0

12. Name William Barnes 0

13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Creighton

15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant W. W. Barnes  
 (b) Address Huntville, Mo.

17. (a) Removal (b) Date thereof 4-19-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Huntville, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) APR 19 1940 (b) [Signature]  
(Date received local registrar)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3225 Montgomerly  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 17, year 1940 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from March 20, 1940, to April 17, 1940; that I last saw him alive on April 17, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions [Signature]  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? [Signature] (Specify type of place) (e) Means of injury 1

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address 1515 Lafayette Date signed 4/17/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

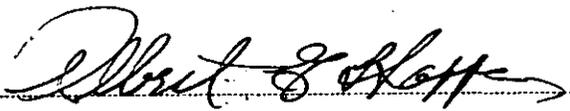
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed



Licensed Embalmer No. 2971

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 this body is not embalmed, above space should be left blank.**