

FILED APR 13 1945

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
JOSEPHINE HEITKAMP MEMORIAL HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3610th McDONALD
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM BARRY

3. (b) If veteran, name war _____

3. (c) Social Security No. 492-07-5109

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MARCELLA

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased SEPT. 25 1873
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>6</u>	<u>3</u>	hr. _____ min. _____

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

10. Usual occupation STEAMFITTER

11. Industry or business FRUCCO CONSTRUCTION

12. Name WILLIAM BARRY

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

14. Maiden name ELIZABETH MULLHOLLAND

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

16. (a) Informant Mrs. Marcella Barry

(b) Address 3610th McDonald Ave. 3-3

17. (a) BURIAL (b) Date thereof April 13 1945
(Place, religion, or rite) (Month) (Day) (Year)

(c) Place: burial or cremation FRUCCO CEMETERY

18. (a) Signature of funeral director L. Mullen Ind. Co.

(b) Address 516 S DELMAR BL.

19. (a) MAR 30 1945 (b) Registrar's signature J. F. Brudek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month McH. day 28th
year 1945 hour 10 minute 40 P. M.

21. I hereby certify that I attended the deceased from 3-24-45
1945 to 3-28 1945

that I last saw him alive on 3-28-45, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Coronary Thrombosis

Due to Cerebral Arteriosclerosis

Due to 108

Other conditions Thrombosis left leg
(includes pregnancy within 3 months of death)

Major findings: ✓

Of operations ✓

Of autopsy ✓

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? _____ (Specify type of place)

(e) Means of injury 0

23. Signature J. F. Cappel or other MD
Address 3284 Franklin Ave. Date signed 3/29/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *H. G. Farris*
Licensed Embalmer No. *3384*
P. O. Address *H. Farris*

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, fact should be so stated above.