

No. 2
-12-45
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42112

FILED DEC 17 1946
378

State File No. _____

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. 10389

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital 16 days
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days
(Specify whether
In this community 80 years
years, months or days)

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. 5350a Conde Street
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. PRINT FULL NAME CATHERINE A. BARBIER

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife William L. Barbier 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 20, 1866
(Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name William Gallagher

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

14. Maiden name Margaret Culligan

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

16. (a) Informant Mrs. Charles Gleason

(b) Address 5350a Conde Street

17. (a) Burial (b) Date thereof 12-6-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director [Signature]

(b) Address 2117 East Grand Blvd.

19. (a) DEC 5 1946 J. F. Brueck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 3rd
year 1946 hour 2 minute 60 A. M.

21. I hereby certify that I attended the deceased from _____
_____, 19____, to _____, 19____;

that I last saw her alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death fracture of right tibia
interoclenus when she fell
to the floor in the bed room
at her home on Nov 3 1946
about 3:00 o'clock P.M.

Due to _____

Other conditions _____
(include 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) Accident

(b) Date of occurrence Nov 3 1946

(c) Where did injury occur? at home
(City or town) (County) (State)

(d) Did injury occur in or about home _____
on farm, if industrial place, in public place?
Home

While at work? _____ (Specify type of place)
Means of injury to above

23. Signature [Signature] (M. D. or other) _____

Address _____ Date signed 12/3/46

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

MOTHER, FATHER

917
%

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 Frank A. Young

Licensed Embalmer No. 3041

P. O. Address 2117 E. Grand

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.