

No. 2
-12-45
5-17-39
I X47070

FILED MAR 30 1947

Registration District No. **21817** Primary Registration District No. **1003** Registrar's No. **3035**

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: Homer C Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days
(Specify whether)

In this community 14 days
years, months or days

3. (a) PRINT FULL NAME Ludonia Barber

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col

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

6. (b) Name of husband or wife Not known 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 6 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

58	1	9	hr. _____ min.
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9. Birthplace Miss. (City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business _____

MOTHER FATHER

12. Name Aaron Barber

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

14. Maiden name Cora ??

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

16. (a) Informant Patient

(b) Address 1424 1/2 Biddle

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR 23/47
(Month) (Day) (Year)

(c) Place: burial or cremation GREENWOOD CEM.

18. (a) Signature of funeral director F.A. GREEN

(b) Address 2915 FRANKLIN

19. (a) MAR 21 1947 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 1424 1/2 Biddle St
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 15
year 1947 hour 11 minute 30 AM.

21. I hereby certify that I attended the deceased from Mar. 1, 1947, to Mar. 15, 1947
that I last saw her alive on Mar. 15, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Cardiovascular Disease with Marked Decompensation

Duration Undet.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations _____

Of autopsy No

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? _____ (Specify type of place)

(c) Means of injury ii

23. Signature Edw. B. Williams (M. D. or other)

Address 2601 N. Whittier Date signed 3/18/47

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

J. A. Green

Licensed Embalmer No

2963

P. O. Address

2915 Franklin

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.