

S. No. 2
M-1/47
7-5-17-39

FEDERAL BUREAU OF VITAL STATISTICS

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

6022

FILED FEB 25 1948

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1519**

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether
In this community **48 yrs**
years, months or days)

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. **1120 N 19th St**
21 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Fred Barnes**

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

4. Sex **MALE** 5. Color of race **Col**
6. (a) Single, widowed, married, divorced **MARRI**
6. (b) Name of husband or wife **Lulu**
6. (c) Age of husband or wife if alive **66** years
7. Birth date of deceased **3 5 1884**
(Month) (Day) (Year)

8. AGE: Years **63** Months **11** Days **5**
If less than one day
.....hr.min.

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

10. Usual occupation **Laborer**

11. Industry or business.....

12. Name **TIM BARNES**
13. Birthplace **UNKNOWN** 9
(City, town, or county) (State or foreign country)

14. Maiden name **11 11**
15. Birthplace **11 11** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Lulu Clark**
(b) Address **1120 N. 19th**

17. (a) **BURIAL** (b) Date there **2-14-48**
(Burial, cremation, or removal) (Month, Day) (Year)
(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Bennie Love**
(b) Address **3103 Washington**

19. (a) **FEB 14 1948** (b) **J. F. B. Beck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **10**
year **1948** hour **7** minute **55** a. M.

21. I hereby certify that I attended the deceased from **Feb. 8** to **Feb. 10**
that I last saw him alive on **Feb. 10**
and that death occurred on the date and hour stated above.
Duration

Immediate cause of death **Probable Bronchogenic Carcinoma with Metastasis**
Undet.

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy **No**

PHYSICIAN

Underline the cause of 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?.....

White at work? (Specify type of place) (c) Means of injury.....

23. Signature **Dr. J. Daniels** (M. D. or other) **0**
Address **2601 N Whittier** Date signed **2/12/48**

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

MOTHER FATHER

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.....

W. Claude Gordon

Licensed Embalmer No.

3489

P. O. Address

4575 Alder

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.