

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31583
Registrar's No. 8401

56336

REG. DIST. NO. 318

PRIMARY REG. DIST. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS 21 1421 Hogan St.,	
3. NAME OF DECEASED a. (First) CASPER b. (Middle) BARNHARDT c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Sept. 20th, 1949	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Sept. 25th 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri
13a. FATHER'S NAME Peter Barnhardt		13b. MOTHER'S MAIDEN NAME Annie unknown	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malnutrition ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinomatosis DUE TO (c) Carcinoma of Rectum II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Functioning Colonostomy	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Hd	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 157X	
22. I hereby certify that I attended the deceased from 7/29/49, 19 to 9/20/49, 19, that I last saw the deceased alive on 9/20/49, 19, and that death occurred at 12:20 PM, from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Casson Hendrix M.D.		23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 9/20/49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE SEP 30 1949	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. SEP 30 1949	REGISTRAR'S SIGNATURE J. B. Lasiter	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.	

WRITE PLAINLY—USING 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_____

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer -

Signed.....

Licensed Embalmer No.....

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, fact should be so stated above.