

APR 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14026

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2494**

1. PLACE OF DEATH a. CITY St. Louis, Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY ST. LOUIS	
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 Webster Groves	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1035 E. Big Bend 4587	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) JAMES	b. (Middle) A. BARADA	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Mar. 12, 1952
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 19, 1899	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZENRY OF WHAT COUNTRY? U
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13a. FATHER'S NAME James A. Barada	13b. MOTHER'S MAIDEN NAME Delia Flynn	14. NAME OF HUSBAND OR WIFE non
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. nn	17. INFORMANT'S SIGNATURE OR NAME Mrs. Dolly Fuller	ADDRESS 1035 E. Big Bend
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 min.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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 4201
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22. I hereby certify that I attended the deceased from **July 1, 1941**, to **March 12, 1952**, that I last saw the deceased alive on **3-12-52**, and that death occurred at **1:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE L. Hoffacker, M.D. (Degree or title)	23b. ADDRESS 5400 Arsenal Street	23c. DATE SIGNED 3/13/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-15-52	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cem.	24d. LOCATION (City, town, or county) (State) Lemay, Mo.
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DATE REC'D BY LOCAL REG. MAR 17 1952	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home	ADDRESS 6322 S. Grand Blvd.
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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 *Arvid Thompson*

Licensed Embalmer No. 1242

P. O. Address 6322 S. 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.