

No. 300
10.48

FILED APR 25 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14029**
Registrar's No. **3300**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 12 4569 Mc Millian	

3. NAME OF DECEASED (Type or Print) a. (First) Henry	b. (Middle)	c. (Last) Barnett	4. DATE OF DEATH (Month) (Day) (Year) April 3 1952
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Dec. 12, 1876	9. AGE (In years last birthday) (Month) (Days) (Hours) (Mins.) 75
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Stella Barnett
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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. No	17. INFORMANT'S SIGNATURE OR NAME Susie Taylor	ADDRESS 4569 Mc Millian
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation		DUE TO (b) Undetermined		Undet.
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Probable G. I. Malignancy		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 4343 H
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22. I hereby certify that I attended the deceased from **2-8**, 19 **52**, to **4-3**, 19 **52**, that I last saw the deceased alive on **4-3**, 19 **52**, and that death occurred at **12 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE Carl W. Harris	(Degree or title) D. O.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 4-4-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 11, 1952	24c. NAME OF CEMETERY OR CREMATORY Oak Dale	24d. LOCATION (City, town, or county) (State) St. Marys Mo.
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DATE REC'D BY LOCAL REG. APR 8 1952	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE E. B. K. Council	ADDRESS 1221 N. Grand
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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 Clarence Adams

Licensed Embalmer No. 4755

P. O. Address 2212 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.