

FILED MAR 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **5895**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2109**

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. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1017 Kuhs Place.				e. STREET ADDRESS (If rural, give location) 4 1017 Kuhs Place., 2049					
3. NAME OF DECEASED (Type or Print) Mary A. Barrett			a. (First) Mary b. (Middle) A. c. (Last) Barrett			4. DATE OF DEATH March 5, 1954			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH March 25 1874			
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Ireland			
11. BIRTHPLACE (City and State or Foreign Country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Dan Reardon		13b. MOTHER'S MAIDEN NAME Julia O'Keefe			
13a. FATHER'S NAME Dan Reardon		13b. MOTHER'S MAIDEN NAME Julia O'Keefe		14. NAME OF HUSBAND OR WIFE Robert M. Barrett, dec'd		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Wm. Dinwoodey, 1017 Kuhs Place					
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis				DUE TO (b) arteriosclerotic Heart disease				3 hours	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c) arteriosclerosis				3 months	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				Senility				2 years	
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)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 53 4200					
22. I hereby certify that I attended the deceased from 12-21 , 19 54 to 3-5 , 19 54 , that I last saw the deceased alive on 3-5 , 19 54 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) James W. Fletes, M.D.				23b. ADDRESS 7270 Natural Bridge		23c. DATE SIGNED 3-6-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-8-54		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri			
DATE REC'D BY LOCAL REG. MAR 8 1954		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph A. Howard 1619 South Grand					

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *John J. Haines*.....

Licensed Embalmer No. *410*.....

P. O. Address *St. Paul*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.