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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 15 1955

State File No. _____ Registrar's No. 9453

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 <u>Mo.</u> b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> | |
| c. LENGTH OF STAY (In this place) | | d. STREET ADDRESS (If rural, give location) <u>3037 a Madison St.</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3037 a Madison St.</u> | | | |

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|--|-------------|-------------------------|---------------------------------------|--|--|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH (Month) (Day) (Year) | | |
| a. (First) <u>Jane</u> | b. (Middle) | c. (Last) <u>Barnes</u> | <u>Oct. 26 1955</u> | | |

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|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|------------------------|----------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Oct. 21, 1898</u> | 9. AGE (In years last birthday) <u>57</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours | IF UNDER 1 MIN. Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|------------------------|------------------------|----------------------|

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|--|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Macon Georgia</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
|--|-----------------------------------|--|---|

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|---------------------------------------|--|--|
| 13a. FATHER'S NAME <u>John Chapel</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Tom Fitzpatrick</u> |
|---------------------------------------|--|--|

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|---|-------------------------------------|---|------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Rosa Smith</u> | ADDRESS <u>3037a Madison</u> |
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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 |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Mitral Insufficiency</u> | | |
| | ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? <u>410X</u> YES <input type="checkbox"/> NO <input 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) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from 8-10, 1955, to 10-26, 1955, that I last saw the deceased alive on 10-26, 1955, and that death occurred at 8 p m., from the causes and on the date stated above.

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|---|-----------------------------|-------------------------------------|----------------------------------|
| 23a. SIGNATURE <u>J.W. Wilkerson</u> <u>J.W. Wilkerson</u> | (Degree or title) <u>MO</u> | 23b. ADDRESS <u>4141 Page Blvd.</u> | 23c. DATE SIGNED <u>10-29-55</u> |
|---|-----------------------------|-------------------------------------|----------------------------------|

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|---|-----------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>10/31/1955</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u> |
|---|-----------------------------|--|---|

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| DATE REC'D BY LOCAL REG. <u>OCT 31 1955</u> | REGISTRAR'S SIGNATURE <u>J. Carl Smith MO</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>I. Thomas</u> | ADDRESS <u>2824 Cass Ave.</u> |
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(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
Student Embalmer

Signed _____

Leroy W. Sumner

Licensed Embalmer No. 4523

P. O. Address 3880 Easton Ave.

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.