

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6110

State File No. _____
Registrar's No. 757

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>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Anthony Hospt</u>		d. STREET ADDRESS (If rural, give location) <u>4727 Clifton</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Anne</u>	b. (Middle) <u>Pauline</u>	c. (Last) <u>Barrett</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 22 1956</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 18, 1896</u>	9. AGE (In years last birthday) (If under 1 year: Months) (If under 12 weeks: Days) (Hours) (Mins.) <u>59</u>
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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>St. Louis, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S</u>
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13a. FATHER'S NAME <u>Julius Schramke</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Roth</u>	14. NAME OF HUSBAND OR WIFE <u>Walter Barrett</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Walter Barrett</u>	ADDRESS <u>4727 Clifton Ave</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, asphyxia, 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>Cancer of liver & generalized metastasis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of breast 5 years ago.</u>		
	DUE TO (c) <u>Injury</u>		
	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 <u>Ca. of breast synch</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>170X</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>None</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Gun</u>
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22. I hereby certify that I attended the deceased from Dec 12, 1955 to Jan 22, 1956, that I last saw the deceased alive on Jan 21, 1956 and that death occurred at 3:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. Carl Smith M.D.</u>	23b. ADDRESS <u>50. Schmale Bldg</u>	23c. DATE SIGNED <u>1-23-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan 25, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>
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DATE REC'D BY LOCAL REG. <u>JAN 23 1956</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Sullivan's</u>	ADDRESS <u>2849 No Euclid A</u>
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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

Albert Mayfield

Licensed Embalmer No. _____

3097

P. O. Address _____

H. Low M

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.