

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28093

STATE FILE NUMBER

FILED SEP 6 1956

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7257**

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN ST. LOUIS (12) Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS (12) 2059 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Pac. Exp. Hosp. Assn. Length of stay in 1b		d. STREET ADDRESS 5758 DeGiverville (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle BYRNE Last BARRY		4. DATE OF DEATH Month AUG Day 6 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 13, 1878
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	11. BIRTHPLACE (City and state or country) COUNTY CORK, IRELAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Timothy Barry	
14. MOTHER'S MAIDEN NAME Johanna Bryne		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Nil.		17. INFORMANT Julia Barry 5768 DeGiverville Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Terminal Pneumonia DUE TO (c) Carcinoma of ESOPHAGUS.			INTERVAL BETWEEN ONSET AND DEATH APRIL 9, 1956 (1st seen) 10 AUG. 5, 1956
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY. Hour _____ a. m. _____ p. m. _____			150 x
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from May 29, 1956 to AUG. 5, 1956 and last saw her ^{her} _{him} alive on AUG. 4, 1956 Death occurred at 5:40 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Clement Sullivan M.D.		22b. ADDRESS Mo Pac Exp. Hosp Assn	22c. DATE SIGNED Aug 5, 1956
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-8-56	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS Harrigan-Sheahan, 4700 Washington,		25. DATE RECD. BY LOCAL REG. AUG 6 1956	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

38.

10/14/47

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 *Elton J. Ruediger*.....

Licensed Embalmer No. *428*

P. O. Address *St. Louis*

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.