

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016347
State File No.

FILED APR 18 1958

318

REG. DIST. NO. PRIMARY REG. DIST. NO. 1003

Registrar's No. 4025

WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

| | | | | | | | | | | | | | | | |
|---|--|------------------------|--------------------|--|--|---|----------------------------|--|----------------|------------------------------------|--|---|--|----------------------------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 4025 | | | | | | | | | |
| 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 OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | | |
| c. LENGTH OF STAY (in this place) | | | | e. STREET ADDRESS (If rural, give location) 257 615 Walnut St. | | | | | | | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 3/ St. Louis State Hospital | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | a. (First) Barthel | | | b. (Middle) | | | c. (Last) Reif | | | 4. DATE OF DEATH (Month) (Day) (Year) April 10, 1958 | | | |
| 5. SEX Male 0 | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married | | | 8. DATE OF BIRTH 3-19-1880 | | | 9. AGE (In years last birthday) 78 | | IF UNDER 1 YEAR Months | | IF UNDER 24 HRS. Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (City and State or Foreign Country) Germany 4 | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13a. FATHER'S NAME Unknown | | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | | 14. NAME OF HUSBAND OR WIFE | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none | | | | 16. SOCIAL SECURITY NO. unknown | | | | 17. INFORMANT'S SIGNATURE OR NAME Oscar Schaeffer Public Administrator | | | | ADDRESS | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) 4200 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome with senile brain disease | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs. 2 yrs. | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | | | | | | 20. AUTOPSY? 2 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? | | | | | | | |
| 22. I hereby certify that I attended the deceased from 11-4, 19 57, to 4-10, 19 58, that I last saw the deceased alive on 4-10-58, 19, and that death occurred at 3:05 p.m., from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 23a. SIGNATURE R. Noblanes M.D. (Degree or title) | | | | | | | | 23b. ADDRESS 5400 Arsenal Street | | | | 23c. DATE SIGNED 4-10-58 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | | 24b. DATE 4-14-58 | | | | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | | | 24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. | | | |
| DATE REC'D BY LOCAL APR 11 1958 | | | | REGISTRAR'S SIGNATURE [Signature] | | | | 25. FUNERAL DIRECTOR'S SIGNATURE Morrell Mortuary | | | | ADDRESS 3710 N. Grand Blvd. | | | |

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 *Louon E. Percy*.....

Licensed Embalmer No. *4094*.....

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.