

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025322
STATE FILE NUMBER
3199

FILED JUL 17 1958 Registration District No. 149 Primary Registration District No. 1005 Registrar's No.

5. 300
1-57

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY JACKSON		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LITTLE SISTERS		Length of stay in (b) 53 yrs	d. STREET ADDRESS (If outside, give location) 5331 Highcamp		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ANTOINETTE REGINA BARCLAY			4. DATE OF DEATH Month Day Year 6 28 58		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-1-66	9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) ST Louis Mo		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME JOSEPH KINDEL		13b. MOTHER'S MAIDEN NAME MARY C. RUDDE		14. NAME OF HUSBAND OR WIFE WILLIAM A. BARCLAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mrs. Frank Jordan U.C. MO	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia (Hypostatic)				INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Pteris sclerosis		20 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertrophic Botryoid (diaphragm)				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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 5/20/58 to 6/28/58 and last saw her alive on 6/26/58 Death occurred at 4:59 PM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Joseph A. Fogarty (Degree or title)			22b. ADDRESS 5811 Truman Rd K. 62616		22c. DATE SIGNED 6/29/58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 6-29-58	23c. NAME OF CEMETERY OR CREMATORY Peter & Paul		23d. LOCATION (City, town, or county) (State) ST Louis Mo
24. FUNERAL DIRECTOR SHEIL FUNERAL HOME		ADDRESS R.I.C. MO		25. DATE RECD. BY LOCAL REG. 6.30.58	26. REGISTRAR'S SIGNATURE neva-minshall

All diseases in Part I must be causally related. No symptoms will be listed.

All diseases in Part I must be causally related.

Joseph A. Fogarty

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *J. P. Sheil*

Licensed Embalmer No. *3625*

P. O. Address *K. C. Mo.*

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.