

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-030233**

**FILED VS SEP 4 1959**

**2 7388**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>82 Yrs.</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Masonic Hospital of Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1116 Bates Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Eleonora</b> Middle <b>Graham</b> Last <b>Barry</b>			4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1959</b>			
---	--	--	--	--	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/8/1877</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR. Hours _____ Min. _____
-------------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Charles, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	--	--	---

13a. FATHER'S NAME <b>Phillip Walter</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Kreienkamp</b>	14. NAME OF HUSBAND OR WIFE <b>William B. Barry</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Evelyn Collier 1116 Bates Ave. (11)</b> 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) <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized Arteriosclerosis</b>	<b>Unknown</b>
	DUE TO (c) <b>450.0</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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. Month, Day, Year
---

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 **March 1950** to **Aug. 23-1959** and last ~~seen~~ <sup>seen</sup> alive on **8-23-1959**  
Death occurred at **4:05 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Harold E. Walters M.D.</b>	22b. ADDRESS <b>3720 Washington St. Louis Mo</b>	22c. DATE SIGNED <b>8-24-59</b>
---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8/26/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
---	-------------------------------	--	--

24. FUNERAL DIRECTOR <b>Alexander and Sons 6175 Delmar Blvd.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>AUG 24 '59</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>
--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Gustav W. Dieterl

Licensed Embalmer No. 4329

P. O. Address St Louis 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.