

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-041175

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10299**

STATE FILE NUMBER

FILED OCT 24 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
Rev. 4/59								
1								
2 <i>212</i>								
3								
4 <i>1</i>								
5 <i>1</i>								
6								
7 <i>1</i>								
8 <i>2</i>								
9								
10								
11								
12 <i>52-0</i>								
13								
<i>52</i>								

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, MISSOURI		Length of stay in 1b 12 days	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 27 Maryland Plaza
3. NAME OF DECEASED (Type or print) GENEVIEVE ANN BARLOW		Middle Last	4. DATE OF DEATH Month Day Year 10-15-63
5. SEX Female	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 6-20-1914
9. AGE (last birthday) 49		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. FEMALE OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis, Mo., U.S.A.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME C. Oscar Lamy	13b. MOTHER'S MAIDEN NAME Mary Sheehan
14. NAME OF HUSBAND OR WIFE John F. Barlow		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.		17. INFORMANT Address John F. Barlow, 27 Maryland Plaza	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma - Primary Cervix DUE TO (b) Metastases to bone, liver, peritoneum DUE TO (c) Carcinoma and pleural effusion. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Inanition and congestive heart failure.			INTERVAL BETWEEN ONSET AND DEATH 6 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 171x		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	
20c. TIME OF INJURY Hour a.m. p.m.		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 11-30-37 to 10-15-63 and last saw her alive on 10-15-63 Death occurred at 5:40 AM on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) E. Charles Th. Duderer M.D.	
22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 10.15.63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-17-1963	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Missouri	
24. FUNERAL DIRECTOR Stock Mortuaries, 9825 Halls Ferry Rd.		25. DATE RECD. BY LOCAL REG. OCT 16 1963	
26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

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 Paul A. Wachten

Licensed Embalmer No. 4787

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.

RECEIVED
STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
ST. LOUIS, MISSOURI