

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

13817

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis, Mo.** (No. **City North No. 2**)
 St. Ward)

File No.....
 Registered No. **6232**
 St. Ward)

2. FULL NAME

Josephine Burns
 (a) Residence No. **1705 Linden**, St., **25** Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred **26** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female. **4. COLOR OR RACE** Negro. **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) **married.**

5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF **James Burns**
 (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **August 14 1920**

7. AGE YEARS **76** MONTHS **6** DAYS **Indefinite**
 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housewife**
 (b) General nature of industry, business, or establishment in which employed (or employer) **—**
 (c) Name of employer **—**

9. BIRTHPLACE (CITY OR TOWN) **Miss.**
 (STATE OR COUNTRY)

10. NAME OF FATHER **Ed Daniel**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Miss.**
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Sarah Williams**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Miss.**
 (STATE OR COUNTRY)

14. INFORMANT **Anna Woodard**
 (Address) **City Hospital #2**

15. FILED **MAY -1 1921** **M. Starkoff**
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 30 1927**

17. I HEREBY CERTIFY That I notified deceased from **March 13**, 19 **27** to **April 30**, 19 **27** that I last saw him alive on **April 27**, 19 **27**, and that death occurred, on the date stated above, at **5:30 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
131
Chronic Nephritis (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **Just definite** (duration) yrs. mos. ds.

18. WHERE DISEASE CONTRIBUTED **129**
 IF NOT AT PLACE OF DEATH, STATE WHERE
 DID AN OPERATION PRECEDE DEATH. **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Chemical & Laboratory**
 (Signed) **J. W. Gray, M.D.**
 , 19 (Address) **City North, Mo.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Washington Park** **DATE OF BURIAL** **May 1 1927**

20. UNDERTAKER **J.C. Thomas** **ADDRESS** **3111 Laclade**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

