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

Do not use this space.

38358

File No. 11023

Registered No.

1. PLACE OF DEATH

County

Registration District No. 791

Township

Primary Registration District No. 1003

City St. Louis (No. City Hospital #2 St. Ward)

2. FULL NAME Frank Burman

(a) Residence. No. 5290 Waterman Ave. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) ~~WIFE OF~~ Violet Burman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE: Years abt 73 | Months ? | Days ? | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mrs. Wm. L. McCheney

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

PARENTS

10. NAME OF FATHER Solomon Burman

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

12. MAIDEN NAME OF MOTHER Dolly ?

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

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

15. FILED DEC -9 1927, 19 Max S. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 7, 1927

17. I HEREBY CERTIFY, That I attended deceased from 11/28, 1927 to 12/7, 1927, that I last saw him alive on 12/7, 1927, and that death occurred, on the date stated above, at 11:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
1 yr
Edema
Anuria (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? not known

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Leo Homey, M. D.

, 19 (Address) City Hosp. #2

*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: Bellefontaine Cem. — DATE OF BURIAL: 12/10 1927

20. UNDERTAKER: A. Russell Funeral Co. — ADDRESS: 2732 Pine

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.