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

Do not use this space.

26262

**1. PLACE OF DEATH**

County St Louis Registration District No. 79 File No.

Township Primary Registration District No. Registered No. 7475

City St Louis No. City Infirmary St. Ward)

**2. FULL NAME** Sue Burks

(a) Residence. No. 5800 Arsenal St., 13 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| F | W | Single |

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/23/1854

| 7. AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 75 | 2 | 13 | |

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

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

PARENTS

10. NAME OF FATHER Henry Burns
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER M. McCormick
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Mrs. M. Effinger
(Address) 420 N 19th Belleville

15. FILED 19 Leo C. Stanley REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/6 1929

17. I HEREBY CERTIFY, That I attended deceased from 7/4/29 7/6 1929, 1929 to 7/6 1929 that I last saw h. alive on 7/6 1929, and that death occurred, on the date stated above, at 5:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr Myocarditis 9 3 6
1 2 3

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Senility

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 4016 McPherson Ave

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) Leo Falleiry M. D.

, 19 (Address) 5800 Arsenal St

*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 St. Louis U. DATE OF BURIAL 7-10 1929

20. UNDERTAKER Walter Richter ADDRESS 3500 Rutger St

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.

92
1