

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

Do not use this space.

25110

**1. PLACE OF DEATH**

County ..... Registration District No. 791  
 Township ..... Primary Registration District No. 1002  
 City St. Louis Mo. City Hospital #2 St. .... Ward) 7310.

**2. FULL NAME**

Willie Burton  
 (a) Residence. No. #12 (2) O Fallon 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 4 yrs. .... mos. .... ds. How long in U. S., if of foreign birth? yrs. .... mos. .... ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>5-30-1892</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>38</u>	<u>1</u>	<u>1</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>Wood-roller</u>				
(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) Miss

PARENTS	10. NAME OF FATHER <u>Bob Burton</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) <u>Miss</u>
	12. MAIDEN NAME OF MOTHER <u>Sue Johnson</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) <u>Miss</u>

14. INFORMANT A. Septimide Creath  
 (Address) City Hospital #2

15. JUL 22 1930 FILED 1930 Max C. Fisher REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-1 1930

17. I HEREBY CERTIFY, That I attended deceased from 5/15, 1930, to 7/1, 1930 that I last saw h. .... alive on 7/1, 1930, and that death occurred, on the date stated above, at 5:00 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pulmonary Tuberculosis  
23A  
 (duration) ..... yrs. 6 mos. .... ds.

CONTRIBUTORY (SECONDARY) MI  
 (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH. Home

DID AN OPERATION PRECEDE DEATH? No DATE OF .....  
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X-Ray, Sputum  
 (Signed) A. E. Hampton, M. D.  
7/1, 1930 (Address) City Hospital #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 Washington U. DATE OF BURIAL 7-9 1930

20. UNDERTAKER Walter Richter ADDRESS 3500 Putger St

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.

