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.

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

32576
Do not use this space.

Registration District No. 791
Primary Registration District No. 1003
Registered No. 8630

1. PLACE OF DEATH OCT 4 1937
(a) County
(b) Township
(c) City St. Louis, Mo. (d) Street No. City Hospital #1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. 5 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Tennie Wilson Burrow
(a) Residence, No. 2043 Park Avenue St. 22
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 26th, 1935

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|
| 2 | 7 | 17 | |

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Black Rock, Arkansas

FATHER
13. NAME King Burrow
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hardy, Arkansas

MOTHER
15. MAIDEN NAME Nellie Wilson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

17. INFORMANT King Burrow
(ADDRESS) 2043 Park Avenue

18. BURIAL, CREMATION, OR REMOVAL
PLACE Imboden, Arkansas DATE Sept. 16th 19 37

19. FUNERAL DIRECTOR Albert H. Hoppe Inc.,
(ADDRESS) 429 N. Euclid Avenue

20. FILED SEP 14 1937 J. F. Bredeck
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 13th 37

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 9:30 P.M.
The principal cause of death and related causes of importance were as follows:

Date of onset

Fracture Skull suffered when he fell from the third floor window to the Lawn Below the window on Sept 13 - 1937 at about 1:45 P.M.

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 9/13/1937
Where did injury occur? St. Louis
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Home
Manner of injury
Nature of injury See above

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Alfred J. Fry M.D.
(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

## STATEMENT BY LICENSED EMBALMER

I, Guy W. Wilkinson, Licensed Embalmer No. 3575

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)**