

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

NOV 15 1937

791

1003

26508  
Do not write in this space.

1. PLACE OF DEATH

(a) County..... Registration District No. ....  
 (b) Township..... Primary Registration District No. .... Registered No. **10085**  
 (c) City *St. Louis City, Moap* (d) Street No. *14th & Lafayette Ave.* 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. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

*Georgia L. Burgess*  
 (a) Residence, No. *923 N. 18th St* St. **21** (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *married*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Elijah C. Burgess*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept. 1st. 1862*  
 7. AGE YEARS *75* MONTHS *1* DAYS *28* If LESS than 1 day, ..... hrs. or ..... min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Housewife*  
 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) *Indiana*

FATHER 13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *"*

MOTHER 15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *"*

17. INFORMANT (ADDRESS) *Mrs. Alex Asher 1920 Franklin Ave.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Memorial Park* DATE *Nov. 11, 1937*

19. FUNERAL DIRECTOR (ADDRESS) *Chas. G. Bull 4432 Washington Ave.*

20. FILED **OCT 30 1937** *J. Predeck* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 28 1937*

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 *6:10 P.M.*

The principal cause of death and related causes of importance were as follows:

*Primary Bronch. Pneumonia*  
*107a*  
*arterio sclerosis*

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?..... Date of injury..... 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *✓*  
 If so, specify.....  
 (Signed) *Joseph W. Quinn* M.D.  
 (Address) *Deputy Coroner*

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.

**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No. ....

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..... *John Ketter* .....

Licensed Embalmer No. *3880* .....

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