

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.

1938

REC'D JUN 7 1938

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

19451  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784  
(b) Township Clayton Primary Registration District No. 1.D.1 Registered No. 879  
(c) City Clayton (d) Street No. St. Louis County Hospital 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

Elizabeth Burnes  
(a) Residence, No. Fee Fee & Franko St.  Maryland Heights, Mo.  
(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 Female 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)

7. AGE YEARS 53 MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Seamstress  
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) 5/12 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

FATHER 13. NAME Thomas Burnes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER 15. MAIDEN NAME Elia Konroy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT Robocca McGraw  
(ADDRESS) 3905-Cottage St. Louis, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Free Cem DATE May 21 38

19. FUNERAL DIRECTOR (NAME) Barnes Bros  
(ADDRESS) operland

20. FILE NO. MAY 21 1938 J. R. Meyer, M.D. D.P.N.  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 15 1938

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 3AM m.  
The principal cause of death and related causes of importance were as follows:

Suicide by cutting instrument  
(razor) Date of onset 5/7/38

Other contributory causes of importance:

Pulmonary embolism

Name of operation Suturing Date of 5/7/38  
What test confirmed diagnosis physical signs an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? suicide Date of injury 5/7/38  
Where did injury occur? in home Maryland Hghts,  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. Mo

Manner of injury Home  
Nature of injury Cut throat with razor  
Throat cut, involving trachea

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify John O'Connell, M.D.  
(Signed) John O'Connell, M.D.  
Coroner of St. Louis County, Mo.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, \_\_\_\_\_

*Earl Hillman*

or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

*Earl Hillman*

Licensed Embalmer No. *3501*

P. O. Address *one clard m*

**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.)**

**If this body is not embalmed, above space should be left blank.**