7 1939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23291

Registration District No. 784 Primary Registration District No. 115 Registrar's No. 1205

1. PLACE OF DEATH:
(a) County SAINT LOUIS
(b) City or town UNIVERSITY CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7247 COLGATE AVE.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community ONE YEAR
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County SAINT LOUIS
(c) City or town UNIVERSITY CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 7247 COLGATE AVE.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME 630 ALBERT FRAZEE BURTT
3. (b) If veteran, name war UNKNOWN
3. (c) Social Security No. UNKNOWN
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife LULA McNINCH BURTT.
6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased OCTOBER 9. 1892 (Month) (Day) (Year)

8. AGE: Years 47 Months 8 Days 27 If less than one day hr. min.

9. Birthplace momence (City, town, or county) illinois (State or foreign country)
10. Usual occupation PLANT MANAGER
11. Industry or business AMERICAN MAGNES STEEL DIV.
FATHER
12. Name ALBERT SANDERS BURTT
13. Birthplace TOWNSEND (City, town, or county) MASS (State or foreign country)
MOTHER
14. Maiden name FLORENCE CAROLINE FRAZEE
15. Birthplace UNKNOWN (City, town, or county) OHIO (State or foreign country)
16. (a) Informant's own signature Lula McNich Burtt
(b) Address 7247 Colgate ave
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 10/39 (Month) (Day) (Year)
(c) Place: burial or cremation CHICAGO HEIGHTS ILL.
18. (a) Signature of funeral director C. R. Lupton Sons
(b) Address 7233 DELMAR BLVD.
19. (a) JUL - 7 1939 (Date received local registrar) (b) R. R. Meyer M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6th
year 1939 hour 6 minute 25 P. M.
21. I hereby certify that I attended the deceased from March 1939 to , 19 ;
that I last saw him alive on July 6th 1939;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	1 hour
Due to Chronic hypertensive heart disease	years
Due to Cardiorenal disease	
Other conditions None (Include pregnancy within 3 months of death)	95 b 2
Major findings: Of operations Not operated upon	
Of autopsy None	

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
(e) While at work? (e) Means of injury
23. Signature Fred W. Clark (M. D. ~~or other~~)
Address 864 Hamilton Blvd. St. Louis, Mo. Date signed 7-7-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DR. CLARK

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, ~~or by~~ Bradford A. Miles, Registered Apprentice No. ..... working under my personal supervision.

Signed Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address St Louis Mo.

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

23291
Do not use this space.

1. PLACE OF DEATH
(a) County St Louis — Registration District No. 784
(b) Township — Primary Registration District No. 118 — Registered No. 1205
(c) City University — (d) Street No. ..... 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 Albert Frazee Burtt
(a) Residence, No. ..... St.
(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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-9-1890

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
47	8	27	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ....., 19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 7-7, 1939 T R Meyer M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-6, 1939

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

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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) J. Clark, M. D.
(Address) 814 Hamilton Bldg St Louis Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.