

JAN 12 1939
Registration District No. **791**

Primary Registration District No. _____

1. PLACE OF DEATH: **1003**
(a) County: _____
(b) City or town: **St. Louis Mo.**
(c) Name of hospital or institution: **5139 Minerva**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME: **MARY BURROWES.620**
3. (b) If veteran, name war: **No**
3. (c) Social Security No.: **No**

4. Sex: **Female** 5. Color or race: **White**
6. (a) Single, widowed, married, divorced: **Single**
6. (b) Name of husband or wife: _____
6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: **June 13, 1853**
(Month) (Day) (Year)

8. AGE: Years: **84** Months: **5** Days: **18** If less than one day: _____ hr. _____ min.

9. Birthplace: **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Housework**

11. Industry or business: _____

MOTHER FATHER { 12. Name: **Michael Burrowes**
13. Birthplace: **Ireland**
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name: **Mary Burrowes**
15. Birthplace: **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: **Mrs. Hill**
(b) Address: **1467 Union St**

17. (a) **Burial** (b) Date thereof: _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: **Calvary**

18. (a) Signature of funeral director: **J. D. ...**
(b) Address: **1399 ...**

19. (a) **DEC 3 1939**
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State: **Mo** (b) County: _____
(c) City or town: **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No.: **5139 Minerva**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month: **Nov** day: **30** 1939
year: **1939** hour: **5:40** minute: _____ P. M.

21. I hereby certify that I attended the deceased from **Nov 1, 1937**
_____, 19____, to **Nov 30, 1939**
_____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: **Debility Senile** Duration: **2 yrs**

Due to: **General Atherosclerosis**

Due to: _____
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: _____

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? _____

While at work? _____ (Specify type of place)
(b) Means of injury: _____

23. Signature: **J. D. ...** (M. D. or other)
Address: **1407 Union St** Date signed: _____

PHYSICIAN
Underline the cause to which death should be charged statistically

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

....., Registered Apprentice No.....

working under my personal supervision.

Signed BWF

Licensed Embalmer No. 1591

P. O. Address.....

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.