DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4262

Registration District No. 791 FILED MAR 12 1940 Primary Registration District No. 1003 Registrar's No. 1092

1. PLACE OF DEATH:

(a) County 1

(b) City or town St. Louis Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Isolation Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-31-40-1:30p.m. to 1-31-40-9:40 p.m. (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DEACESED:

(a) State Missouri (b) County 20

(c) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL")

(d) Street No. 2544 Warren (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME June Burt

3. (b) If veteran, name war Child

3. (c) Social Security No. Child

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Child

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased October (Month) 1 (Day) 1936 (Year)

8. AGE: Years 3 Months 3 Days 30 If less than one day ____ hr. ____ min.

9. Birthplace St. Louis, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation Nil 0

11. Industry or business 0

FATHER 12. Name Donald Burt

13. Birthplace Missouri (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Mamie Gould

15. Birthplace Kansas City, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. Lane

(b) Address 5600 Arsenal St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/3/40 (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) FEB 2 1940 (Date received local registrar) (b) J. B. Reedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31 year 1940 hour 9:40 p.m. minute ____ M.

21. I hereby certify that I attended the deceased from 1-31-40-1:30pm, 19__, to 1-31-40-9:40 p.m. 19__, that I last saw her alive on 1-31-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Diphtheria, laryngeal.	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: Same.	

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)

While at work? (e) Means of injury

23. Signature Geo. A. Boehm M.D. (M. D. or other)

Address 5600 Arsenal Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....Guy W Wilkinson

Licensed Embalmer No.....3575

P. O. Address.....

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.)

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