

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 1022

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community 4 years
years, months or days)

3. (a) PRINT FULL NAME James Buriil 640

3. (b) If veteran, name war ? 3. (c) Social Security No. ?

4. Sex male 5. Color or race colored 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Susie Britt Buriil 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Nov. 3 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 6 22 hr. min.

9. Birthplace Franklin County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation ndl.

11. Industry or business

12. Name George Buriil

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

14. Maiden name Fannie Morris

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

16. (a) Informant Susie Buriil

(b) Address 1136 Leonard ave.

17. (a) Burial (b) Date thereof 5/29/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director C. W. Roberts

(b) Address 3735 Lucas ave.

19. (a) MAY 28 1940 (b) [Signature]
(Date received locally) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
(d) Street No. 630 Bell Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1940 hour 2 minute :00 A. M.

21. I hereby certify that I attended the deceased from 5-21-40
_____ 19, to 5-25-40, 19____
that I last saw him alive on 5-25-40, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Duration 5 day

Due to Hypertensive Cardiovascular
renal disease 10%
Due to _____

Other conditions 131
(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)
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed 5/23/40

Duration
5 day
10 %
PHYSICIAN
Underline
the cause to
which death
should be
charged sta-
tistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

96
22

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 ME

Chas. Gairis

, Registered Apprentice No. 2349

working under my personal supervision.

Signed Chas. Gairis

Licensed Embalmer No. 2349

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.