V. S. No. 2
OM—8-43
ev. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 23 19

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32112

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 8741

1. PLACE OF DEATH:

(a) County

(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: St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2½ Weeks, (Specify whether
In this community Life, 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oac 17

(c) City or town St. Louis, 9
(If outside city or town limits, write "RURAL")

(d) Street No. 5342 Delor, 14
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Mary M. Burns,

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife James J.

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Oct 15, 1883
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
50	11	28	hr. min.

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

10. Usual occupation Housewife,

11. Industry or business

FATHER
12. Name Thomas J. Gunn,
13. Birthplace St. Louis, Mo., 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Margaret McDonald,
15. Birthplace St. Louis, Mo., 0
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. James Burns,
(b) Address 5342 Delor

17. (a) Burial (b) Date thereof 10/16/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Oscar J Hoffmeister
(b) Address 4016 Chippewa,

19. (a) OCT 14 1944 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

844

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13
year 1944 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from Nov 15, 1944 to 10-13, 1944
that I last saw her alive on 10-13-44, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

Duration 1½ yrs.

Due to

Due to

93d

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

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) No
(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 J J Hammond (M. D. or other) M.D.
Address 634 N Grand Date signed 10/14/44

(Licensed Embalmer's Statement on Reverse Side)

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 Albert G. Hoppe

Licensed Embalmer No. 2971

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, fact should be so stated above.