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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29207

FILED OCT 6 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8366

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
✓ Columbia Brewing Co., 2000 Madison
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 1723
(If outside city or town limits, write "RURAL")
(d) Street No. 2828 Shenandoah Ave. 9
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Walter E. McBurney

3. (b) If veteran, name war

3. (c) Social Security No. 493-07-7326

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 5 (Day) 1884 (Year)

8. AGE: Years 61 Months 6 Days 21 If less than one day hr. min.

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

10. Usual occupation Bottler

11. Industry or business Columbia Brewing Company

FATHER
12. Name William O. McBurney
13. Birthplace (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Sarah Pence
15. Birthplace (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Elenore Stephens
(b) Address 2828 Shenandoah Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep. 28, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Walker Funeral
(b) Address 3634 Gravois Avenue

19. (a) SEP 27 1945 (Date received local registrar) J. F. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26 year 1945 hour 2 minute 30 A. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	
Due to	
Due to Coronary Sclerosis	
Other conditions (Include pregnancy within 3 months of death) 94	

Major findings:
Of operations
Of autopsy

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 9

23. Signature [illegible] (M. D. or other)
Address [illegible] Date signed 9/27/45

(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.....

Licensed Embalmer No.....

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.