

FILED **894** **3 1945**

Registration District No. _____

Primary Registration District No. **3063**

Registrar's No. **2522**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Webster Groves Clayton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospl 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: **In hospital or institution**
In this community **about 10 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis 91**
(c) City or town **Webster Groves**
(If outside city or town limits, write "RURAL")
(d) Street No. **20 Wraymeyer**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

James Burnett

3. (b) If veteran, **World War 2** name war **World War 2**
3. (c) Social Security No. _____

4. Sex **Male 2** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Stella Burnett** 6. (c) Age of husband or wife if alive **27** years

7. Birth date of deceased: **8** (Month) **28** (Day) **1909** (Year)

8. AGE: Years **36** Months **2** Days **1** If less than one day hr. _____ min. _____

9. Birthplace **Gray Sumitt, Mo.** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **Soldier**

11. Industry or business _____

FATHER {
MOTHER {

12. Name **James Burnett**

13. Birthplace **Franklin Co.** (City, town, or county) (State or foreign country) **0**

14. Maiden name **Robena Roberts**

15. Birthplace **Franklin Co.** (City, town, or county) (State or foreign country) **0**

16. (a) Informant **Robena Burnett**

(b) Address **228 East Ave.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11 3 1945** (Month) (Day) (Year)

(c) Place: burial or cremation **father Dickson**

18. (a) Signature of funeral director **J.C. Lewis**

(b) Address **228 East Webster Groves**

19. (a) **11-2-45** (Date received from registrar) (b) **C. J. M. Loran M.D.** (Registrar's signature) **2522**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **30th** year **1945** hour **1.30** minute **8** 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.

Immediate cause of death **As a result of a dagger stab wound on left side of back between 9th & 10th ribs administered by his wife,**

Due to **Justifiable Homicide**

Other conditions **167** (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) **Justifiable Homicide**

(b) Date of occurrence **10-30-45**

(c) Where did injury occur? **Webster Groves, Mo.** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **In a home**

While at work? **no** (Specify type of place) Means of injury **Incised wound**

23. Signature **Arnold J. Willman** (Coroner)

Address **Clayton Mo.** Date signed **11-1-45**

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

NOV 19 1945

FEB 23 1946

DEC 29 1945

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 *J. Lewis*

Licensed Embalmer No. *2027*

P. O. Address *Hebert Brown*

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.

Registration District No. 317 Primary Registration District No. 3063

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 Co. Hospital
(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 James Burnett

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

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

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

7. Birth date of deceased Aug 28 1940
(Month) (Day) (Year)

8. AGE: Years 36 Months 2 Days mo (If less than one day, _____ min.)

9. Birthplace (City, town, or county) _____ (State or foreign country) mo

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11-10-45 (b) E. M. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ after on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

DEC 29 1945

FEB 23 1946

34546