

S. No. 2
M-5-43
5-17-39
P I X36671

#51212
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38982**
Registrar's No. **11184**

FILED JAN 5 1946
318

Registration District No. _____
Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital-Max C. Starckloff Memorial**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **14 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO.** (b) County _____
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
Street No. **3429 JUNIATA ST.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **ALPHA BURNETT**
3. (b) If veteran, name war **NO**
3. (c) Social Security No. _____
4. Sex **FEMALE** Color or race **W**
5. (a) Single, widowed, married, divorced **WIDOW**
6. (b) Name of husband or wife **ALPHA BURNETT**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **NOV. 20 - 1881**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **19th**
year **1945** hour **5:20** minute _____ P _____ M.
21. I hereby certify that I attended the deceased from **12/5/45**
_____, 19____, to **12/19/45**, 19____;
that I last saw h. **er** alive on **12/19/45**, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
64 | **0** | **29** | _____ hr. _____ min.

Immediate cause of death **Arteriosclerotic Heart Disease**
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) **93**
Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace **MAKANDA ILLINOIS**
(City, town, or county) (State or foreign country)
10. Usual occupation **HOUSEKEEPER**
11. Industry or business **OWN**
MOTHER FATHER { 12. Name **JAMES W. NEBER**
13. Birthplace **ILLINOIS**
(City, town, or county) (State or foreign country)
14. Maiden name **MARY ALICE UNK**
15. Birthplace **ILLINOIS**
(City, town, or county) (State or foreign country)
16. (a) Informant **Mrs. Faye Davis**
(b) Address **3429 Junata**
17. (a) **BURIAL** (b) Date thereof **Dec 22-45**
(Burial, cremation, or reinterment) (Month) (Day) (Year)
(c) Place: burial or cremation **LAUREL HILL CEM.**
18. (a) Signature of funeral director **E. J. Schmir**
(b) Address **3125 Lafayette St. St. Louis**
19. (a) **DEC 20 1945** (b) **J. F. Broderick**
(Date registered) (Registrar's signature)

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)
(a) Mode of injury _____
23. Signature **James J. Smith** (M.D.) **12/20/45**
Address **1515 Lafayette** Date signed _____

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

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.....

Jose B. Kollmer

Licensed Embalmer No. *4014*

P. O. Address *St. Louis Mo 4*

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.