S. No. 2
M—5-43
5-17-39
I X36671

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. 7298

FILED FEB 20 1946

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1473

1. PLACE OF DEATH:

(a) County
(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:
Malcom Bliss Hospital 0
(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 1017
(If outside city or town limits, write "RURAL")
(d) Street No. 4102 E. Lexington Ave. 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME SAMUEL C. BURNS
3. (b) If veteran, name war
3. (c) Social Security No. 488-18-3203
4. Sex male 0
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Barbara Burns
6. (c) Age of husband or wife if alive years
7. Birth date of deceased January 3rd 1868 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
78	1	9	hr. min.

9. Birthplace St. Louis, Missouri 0 (City, town, or county) (State or foreign country)
10. Usual occupation Maintenance Man
11. Industry or business City of St. Louis

FATHER
12. Name Samuel C. Burns
13. Birthplace So. Carolina / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Nancy Cooper
15. Birthplace So. Carolina / (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Barbara Burns- Wife,
(b) Address 4102 E. Lexington Ave.
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-14-46 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crematory
18. (a) Signature of funeral director Sullivan Brothers,
(b) Address 2849 North Euclid Avenue,
19. (a) FEB 13 1946 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 12th year 1946 hour 4:30 minute P. M.
21. I hereby certify that I attended the deceased from Sept 1945 to Feb. 12 1946 that I last saw him alive on Feb 12 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
LOBAR PNEUMONIA	5 Days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Senile Psychosis	

Major findings:
Of operations
Of autopsy Not Done

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?
While at work? (Specify type of place) (e) Nature of injury
23. Signature R. L. Stubblefield (M. D. or other) 0
Address 1420 Brattun Date signed 2-12-46

(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 Robert L Brinkman

Licensed Embalmer No. 3553

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.