No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 21 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

34736

State File No. 1

Registration District No. 367 Primary Registration District No. 6076 Registrar's No. 3870

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days)
In this community 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County —
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. Pacific Hotel (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lee Andrew Burns
3. (b) If veteran, name war Spanish-American
3. (c) Social Security No. unknown
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Feb (Month) 15 (Day) 1877 (Year)

8. AGE: Years 69 Months 8 Days 0 If less than one day hr. min.

9. Birthplace Van Leer (City, town, or county) Tenn. (State or foreign country)
10. Usual occupation None
11. Industry or business —
FATHER 12. Name Thomas Burns
FATHER 13. Birthplace — (City, town, or county) Ohio (State or foreign country)
MOTHER 14. Maiden name Missouri Hudson
MOTHER 15. Birthplace — (City, town, or county) Ohio (State or foreign country)
16. (a) Informant Hospital Record
(b) Address Koch Hospital
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-17-46 (Month) (Day) (Year)
(c) Place: burial or cremation Dickson, Tennessee
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) 10-17-46 (Date received local registrar) (b) Ruth Allen MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 15 year 1946 hour 8 minute 40 P.M.
21. I hereby certify that I attended the deceased from Oct 4, 1946, to Oct 15, 1946; that I last saw him alive on Oct 15, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Pulmonary Tuberculosis	unknown
Due to —	
Due to — 136	
Other conditions — (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Charles Silverberg (M.D. or other) M.D.
Address Koch Hospital, Koch, Mo. Date signed 10/16/46.

(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 Henry M. Brammer

Licensed Embalmer No. 4200

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.