

No. 2
1/47
5-17-39

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

39493

FILED DEC 6 1947 318

1003

State File No. 10942

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County..... St. Louis, Mo
(b) City or town..... St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Alexian Bros. Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... 0 (Specify whether years, months or days)

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. 2421a Cass Avenue
20 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... Robert A. Burns

3. (b) If veteran, name war..... 3. (c) Social Security No. # 497-16-2856

4. Sex..... male 0 5. Color or race..... white
6. (a) Single, widowed, married, divorced..... married
6. (b) Name of husband or wife..... Sarah A.K. Burns
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... Nov. 23rd 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 0 5 hr. min.

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

10. Usual occupation..... Steamfitter

11. Industry or business.....

12. Name..... Michael Burns

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

14. Maiden name..... Nora Powers

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

16. (a) Informant..... Mrs. Sarah Burns - Wife

(b) Address..... 2421a Cass Ave.

17. (a) burial (b) Date thereof..... 12-1-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Calvary Cemetery

18. (a) Signature of funeral director..... Sullivan Brothers

(b) Address..... 2849 North Euclid Ave.

19. (a) JUV 30 1947 (b) J. F. Brideck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Nov. 28th
year..... 1947 hour..... 1:35 minute..... 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.

Immediate cause of death..... Color thrombus
arteries of ribs which struck by a
fire cylinder which he was holding
while led from a truck carrying
fire to full to the ground
cylinder to fall to in chest of the
deceased. Chemical Co. 2102
Street Ground 11:00 AM Oct 3 1947

Duration

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... Oct 3 1947
(c) Where did injury occur?.....
(City or town) (Country) (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..... Thomas F. Callahan (M.D. or other).....
Address..... Date signed..... 11-29-47

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

MOTHER FATHER

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 Blair R. Padwell
Licensed Embalmer No. 4077

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.

Registration District No. 214

Primary Registration District No. 1003

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: _____
(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 Robert A Burns

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

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

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

7. Birth date of deceased Nov. 23 (Month) (Day) (Year)

8. AGE: Years 59 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Steamfitter

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Bredon (Date received local registrar) (Registrar's 4 (Date))

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 _____ Day _____ year 1947 hour _____ minute _____ M. _____

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

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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

MOTHER, FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

DEC 11 1947

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