

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

2756256

FILED AUG 28 1948

Registration District No. 010

Primary Registration District No. 1003

Registrar's No.

7302

1. PLACE OF DEATH:

(a) County ST LOUIS
(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BEACONESS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 DAY (Specify whether
In this community 1 DAY
years, months or days)

3: (a) PRINT FULL NAME MARY BARBARA BURRELL

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

4. Sex F 5. Color or race W
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 AUG-17-1948
(Month) (Day) (Year)

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

9. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation INFANT11. Industry or business —

MOTHER FATHER { 12. Name WILLIAM A BURRELL
13. Birthplace EMPORIA KANSAS
(City, town, or county) (State or foreign country)
14. Maiden name MARY MARGARET SNOW
15. Birthplace E. ST LOUIS ILLINOIS
(City, town, or county) (State or foreign country)

16. (a) Informant WM A BURRELL
(b) Address 1535 GRANT RD

17. (a) BURIAL (b) Date thereof AUG-20-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OAK HILL CEM

18. (a) Signature of funeral director Parker and Co

(b) Address W. WEBSTER GROVES MO

19. (a) AUG 20 1948 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS
(c) City or town WEBSTER GROVES 96
(If outside city or town limits, write "RURAL")
(d) Street No. 1535 GRANT RD 7
NR. (If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Aug day 18th
year 1948 hour 8 minute 30 P

21. I hereby certify that I attended the deceased from Aug. 17
to Aug. 18, 1948
that I last saw him alive on Aug. 18, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral anoxia Duration 36 hr.

Due to Exhalation of secretions
at delivery.

Due to Pulmonary atelectasis 36 hrs.
Other conditions R
(Include pregnancy within 3 months of death)

Major findings:
Of operations 161
Of autopsy —
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) Means of injury —
23. Signature [Signature] (M. D. or other)
Address 337 N. Euclid Ave Date signed 8/19/48
St Louis

(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.

no Embalming

Signed *W. E. Aldrich*

Licensed Embalmer No. *1332*

P. O. Address *Bellevue, Mo*

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.