

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31640

State File No.

#37533

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8591**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		a. STATE Illinois b. COUNTY Shelby	
c. LENGTH OF STAY (In this place) 0		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Shelbyville	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) Route 4	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year
WILLIAM	BURFORD	BURFORD	Oct.	4th	1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER	8. DATE OF BIRTH Feb. 8, 1884	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
Attendant	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Hospital	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Henry Burford		13b. MOTHER'S MAIDEN NAME Sarah Unknown		14. NAME OF HUSBAND OR WIFE Helen Burford	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. Leveta Homan, Shelbyville, Ill.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 days
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arteriosclerosis		+ 1 yr
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		3.32X
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4570
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22. I hereby certify that I attended the deceased from 10/2/49, 1949, to 10/3/49, 1949, that I last saw the deceased alive on 10/3/49, 1949, and that death occurred at 10:40am, from the causes and on the date stated above.

23a. SIGNATURE Donald S. Taylor M.D.	(Degree or title)	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 10/3/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-3-49	24c. NAME OF CEMETERY OR CREMATORY Glenwood	24d. LOCATION (City, town, or county) (State) Shelbyville, Ill.
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DATE REC'D BY LOCAL REG. OCT 5 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING 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 ME

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

George W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St. Louis, 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.