

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34988

State File No. 9361

BIRTH NO. 67183-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION MISSOURI BAPTIST HOSPITAL | | d. STREET ADDRESS (If rural, give location) 1023a Sells Avenue | |

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|--|--|-------------|---|-----------|--|
| 3. NAME OF DECEASED (Type or Print) Infant Burr | | | 4. DATE OF DEATH (Month) (Day) (Year) 10-13-49 | | |
| a. (First) | | b. (Middle) | | c. (Last) | |

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|---|---------------------------|--|------------------------------|---|--------------------------------|--------------------------------|
| 5. SEX M. | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 10-13-49 | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Mins |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |

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| 13a. FATHER'S NAME Max Leo Burr | 13b. MOTHER'S MAIDEN NAME Janette Marie Nieshoff | 14. NAME OF HUSBAND OR WIFE |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME | ADDRESS |
|---|-------------------------|-----------------------------------|---------|

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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital absence of brain tissue | | INTERVAL BETWEEN ONSET AND DEATH 1 hr & 44 min |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | |
| | DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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) |
| 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? 7.531 |

22. I hereby certify that I attended the deceased from 10-13, 1949, to 10-13, 1949, that I last saw the deceased alive on 10, and that death occurred at 2:00 pm, from the causes and on the date stated above.

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| 23a. SIGNATURE M. C. Gerst M. D. | 23b. ADDRESS 2114 E. Grand | 23c. DATE SIGNED |
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|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE OCT 31 1949 | 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board | 24d. LOCATION (City, town, or county) (State) |
|---|--------------------------|--|---|

| | | |
|---|---------------------------------------|---|
| DATE REC'D BY LOCAL REG. OCT 31 1949 | REGISTRAR'S SIGNATURE J. B. Sauter | 25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo. |
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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_____

....., Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Licensed Embalmer No.....

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.