

FILED JUN 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17889**
Registrar's No. **4655**

318

PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		State File No. 17889		Registrar's No. 4655									
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis													
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis			c. LENGTH OF STAY (If in this place) 12 hours			c. CITY (If outside corporate limits, write RURAL and give township) Jennings			4158								
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital				d. STREET ADDRESS (If rural, give location) 6333 Stratford Ave.													
3. NAME OF DECEASED (Type or Print)		a. (First) John		b. (Middle) W.		c. (Last) Burgess, Sr.		4. DATE OF DEATH (Month) (Day) (Year) May 16, 1951									
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Oct. 29, 1876		9. AGE (In years last birthday) 74		10. MONTHS 7		11. DAYS 16		12. HOURS 16		13. MIN. 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car Operator				10b. KIND OF BUSINESS OR INDUSTRY Public Service				11. BIRTHPLACE (State or foreign country) Steelville, Mo.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13a. FATHER'S NAME James Burgess				13b. MOTHER'S MAIDEN NAME Unknown				14. NAME OF HUSBAND OR WIFE Mabel Burgess									
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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mabel Burgess-6333 Stratford											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic coronary heart disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND DEATH 1 day							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		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? H201			
22. I hereby certify that I attended the deceased from 5-16, 1951 , to 5-16, 1951 , that I last saw the deceased alive on 5-16, 1951 , and that death occurred at 11 A m., from the causes and on the date stated above.										23a. SIGNATURE Arthur K. Juskeford MD		23b. ADDRESS 3604 Washington		23c. DATE SIGNED 5-18-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5/19/51		24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.											
DATE REC'D BY LOCAL REG. MAY 18 1951		REGISTRAR'S SIGNATURE J. B. Lanter				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral - 1905 Union Blvd.											

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Albert R. Thompson

Signed.....
Student Embalmer

Licensed Embalmer No.....

4657

P. O. Address.....

H. Jones

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.