

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6909

State File No. ....

FILED MAR 12 1952

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <u>3065</u>		Registrar's No. <u>86</u>			
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Glendale, 22</u>		c. LENGTH OF STAY (In this place) <u>3 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Glendale 22</u> <u>4651</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Res. 939 Chelsea</u>				d. STREET ADDRESS (If rural, give location) <u>65 939 Chelsea</u>					
3. NAME OF DECEASED a. (First) <u>William</u> (Type or Print)			b. (Middle) <u>Edward</u>		c. (Last) <u>Burr</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 12, 1952</u>		
5. SEX <u>♂</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 7, 1889</u>		9. AGE (In years last birthday) <u>62</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 1 WEEK: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professional Soldier, Regular Army</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>Portland, Oregon</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>General Edward Burr</u>			13b. MOTHER'S MAIDEN NAME <u>Katherine Green</u>			14. NAME OF HUSBAND OR WIFE <u>Julie Goode Burr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI &amp; WW2</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Robert W. Knapp</u> ADDRESS <u>4600 McPherson Ave</u>					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
19a. DATE OF OPERATION _____		19b: MAJOR FINDINGS OF OPERATION <u>331X</u>						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) _____					
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? _____					
22. I hereby certify that I attended the deceased from <u>Jan 8, 1952</u> to <u>Jan 12, 1952</u> , that I last saw the deceased alive on <u>Jan 10, 1952</u> , and that death occurred at <u>12:40 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Herbert M. Gains</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Parkwood Mo</u>			23c. DATE SIGNED <u>1/12/52</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>January 1252</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>			
DATE REC'D BY LOCAL REG. <u>1-13-52</u>		REGISTRAR'S SIGNATURE <u>Herbert M. Gains</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alexander &amp; Sons</u>		ADDRESS <u>6175 Delmar</u>			

(Licensed Embalmer/Embalmers on Reverse Side)

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

No. 300  
S.S. 48  
1-1-52

Dr. Quentin M. Gaines  
508 N. Kirkwood Rd.  
Ki. 0035

SEP 4 1954

SEP 22 1954

**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.....  
Student Embalmer

Signed jos. E. McCulloh

Licensed Embalmer No. 2460

P. O. Address 6170 P. Uman

**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.