

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**7412**

State File No. \_\_\_\_\_

FILED FEB 25 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1216**

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give OR TOWN) <b>St. Louis, Missouri</b> c. LENGTH OF STAY (in this place) <b>1 week</b> d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> d. STREET ADDRESS (If rural, give location) <b>5532 Alcott Ave.</b>	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>EDWIN</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>JANUARY 31, 1953</b>	
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>married</b>	<b>8. DATE OF BIRTH</b> <b>May 17, 1895</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Floor Man Gen. Cable</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Altonburg, Mo.</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13a. FATHER'S NAME</b> <b>John Burroughs</b>	
<b>13b. MOTHER'S MAIDEN NAME</b> <b>Minnie Schulenburg</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Mrs. Vera M. Burroughs</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>1st W.W.</b>		<b>16. SOCIAL SECURITY NO.</b> <b>493-07-0863</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Vera M. Burroughs</b>
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Pneumococcal Meningitis</b>  <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Pneumococcal Pneumonia</b>  DUE TO (c) _____  <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.	
<b>19a. DATE OF OPERATION</b> _____		<b>19b. MAJOR FINDINGS OF OPERATION</b> _____	
<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>21. INTERVAL BETWEEN ONSET AND DEATH</b> _____	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <b>493 X</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>1-26-53</u> , 19 <u>53</u> , to <u>1-31-53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>1-31-53</u> , 19 <u>53</u> , and that death occurred at <u>7:40 P</u> m., from the causes and on the date stated above.			
<b>23a. SIGNATURE</b> (Degree or title) <b>Paul W. Larson, M.D.</b>		<b>23b. ADDRESS</b> <b>1515 Lafayette Avenue</b>	<b>23c. DATE SIGNED</b> <b>2-2-53</b>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>removal</b>	<b>24b. DATE</b> <b>2-4-53</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>New Bethlehem Cemetery</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
<b>DATE REC'D BY LOCAL REG.</b> <b>FEB 2 1953</b>	<b>REGISTRAR'S SIGNATURE</b> <b>J. Carl Smith M.D.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Math Hermann &amp; Son, Inc. 2161 E. Fair Ave.</b>

(Licensed Embalmer's Statement on Reverse Side)

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.

Signature \_\_\_\_\_  
Student Embalmer

Signed \_\_\_\_\_

*Glen W. Katz*

Licensed Embalmer No. \_\_\_\_\_

*3737*

P. O. Address \_\_\_\_\_

*St. Louis, Mo.*

~~Name:~~ 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 the body is not embalmed, fact should be so stated above.