No. 300
No. 48

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

FILED MAR 11 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7413
Registrar's No. 1810

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis Mo
c. LENGTH OF STAY (In this place): 7 yrs, 11 mo, 14 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: City Infirmary, Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis Mo
d. STREET ADDRESS (If rural, give location): 5600 Arsenal ST.

2139

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3. NAME OF DECEASED (Type or Print)
a. (First): Isabelle
b. (Middle):
c. (Last): Burrow

4. DATE OF DEATH (Month) (Day) (Year): 2 14 53

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 3/3/85
9. AGE (In years last birthday): 67 — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Thebes, Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: John Jones
13b. MOTHER'S MAIDEN NAME: Molly?
14. NAME OF HUSBAND OR WIFE: Rubin Bert Burrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: City Infirmary Record 5800 Arsenal St.

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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

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.* Generalized Arteriosclerosis — 8 years?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 443X

22. *I hereby certify that I attended the deceased from* 8/1, 19 52, *to* 2/14, 19 53, *that I last saw the deceased alive on* 2/10, 19 53, *and that death occurred at* 11:55 AM., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. C. Goehausen MD
23b. ADDRESS: 5600 Arsenal St
23c. DATE SIGNED: 2-16-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 2-15-53
24c. NAME OF CEMETERY OR CREMATORY: Fairview
24d. LOCATION (City, town, or county) (State): Dyersburg, Tenn

DATE REC'D BY LOCAL REG.: FEB 16 1953
REGISTRAR'S SIGNATURE: J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.
(Licensed Embalmer's Statement on Reverse Side)

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 John J. Hanner

Licensed Embalmer No. 4108

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.