

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29825**
Registrar's No. **7370**

FILED AUG 20 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Washington	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cadet 1100	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital		d. STREET ADDRESS (If rural, give location) R.R.#1	
3. NAME OF DECEASED a. (First) Joseph b. (Middle) c. (Last) Burbon		4. DATE OF DEATH (Month) (Day) (Year) 7 29 1953	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) -	8. DATE OF BIRTH July 28, 1953
9. AGE (In years last birthday)		10. MONTHS	11. DAYS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY? 0	
13a. FATHER'S NAME Raymond Burbon		13b. MOTHER'S MAIDEN NAME Margaret Dean	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Raymond Burbon ADDRESS Cadet, Missouri	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid Hemorrhage 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. Atelectasis - incomplete Patent Ductus	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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) 760, 0	
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 6⁴⁵ PM 28 July 1953 , to 12¹⁰ PM 29 July 1953 , that I last saw the deceased alive on 12¹⁰ PM 29 July 1953 , and that death occurred at 12¹⁰ PM , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Robert Jacob Pfeffel M.D.		23b. ADDRESS Firmin Desloge Hospital	
23c. DATE SIGNED 7-29-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 7-30-1953		24c. NAME OF CEMETERY OR CREMATORY St. Joachims Cemetery	
24d. LOCATION (City, town, or county) (State) Old Mines, Mo		25. FUNERAL DIRECTOR'S SIGNATURE J. Carl Smith ADDRESS Potosi, Mo	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUL 29 1953		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Potosi, Mo	

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

Mary M. Smith

Licensed Embalmer No. *4394*

P. O. Address *Potosi, Mo*

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.