THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 4 - 1953

State File No. 40250

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11062

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 47 yrs.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 3412a Delmar Blvd

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY: 2219
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 0
d. STREET ADDRESS (If rural, give location): 21 3412a Delmar Blvd

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

4. DATE OF DEATH (Month) (Day) (Year): 11 19 53

5. SEX: F. 3

6. COLOR OR RACE: Col

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow 2

8. DATE OF BIRTH: 10-22-1891

9. AGE (In years last birthday): 62
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): Cook

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (City and State or Foreign Country): Wright City Mo 0

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Richard Edward

13b. MOTHER'S MAIDEN NAME: Clara Simms

14. NAME OF HUSBAND OR WIFE: Eugene Burkins, Dead

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: Lester Edward 558 Washington St. Charles Mo

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) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Occlusion
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? No 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): 420.1

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 1251 m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph [illegible] Signature Form 3

23b. ADDRESS: 1300 Clark

23c. DATE SIGNED: 11/21/53

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE: 11-23-53

24c. NAME OF CEMETERY OR CREMATORY: Wright City Cemetery

24d. LOCATION (City, town, or county) (State): Wright City MO.

DATE REC'D BY LOCAL REG.: NOV 21 1953

REGISTRAR'S SIGNATURE: J Earl Smith MD MKB

25. FUNERAL DIRECTOR'S SIGNATURE: GUS Louie

ADDRESS: 2430 Dickson St.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK

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 Arthur L. Heilliard

Licensed Embalmer No. 4221

P. O. Address 4524 Aldin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.