

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9922
2751

FILED APR 2 1954

State File No. _____
Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 4247 Grace Ave.				e. STREET ADDRESS (If rural, give location) 15 4247 Grace Ave.						
3. NAME OF DECEASED (Type or Print) Mary			a. (First) _____		b. (Middle) C.		c. (Last) Burns		4. DATE OF DEATH (Month) (Day) (Year) March 24, 1954	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Nov. 5, 1870		9. AGE (In years last birthday) 83	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) Housekeeping			10b. KIND OF BUSINESS OR INDUSTRY At Home			11. BIRTHPLACE (City and State or Foreign Country) Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Edward Burns			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE None				
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. 498-12-7296		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wm. A. Brass - 4247 Grace Ave.					
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) Cerebral apoplexy ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic arteriosclerosis DUE TO (c) arteriosclerosis - vascular Dis. Eyes II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH Nov 20-54		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						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 Nov 21, 1954 , to Mar 24, 1954 , that I last saw the deceased alive on Mar 22, 1954 , and that death occurred at 2:00 P. m. , from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) Walter J. Matzel, M.D.				23b. ADDRESS 2739 No Grand Bl			23c. DATE SIGNED MAR 25 1954			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Mar. 27, 1954		24c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		24d. LOCATION (City, town, or county) (State) Alton, Illinois				
DATE REC'D BY LOCAL REG. MAR 26 1954		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker - Helderle - 3634 Gravois Ave.					

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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No.....
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.