

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31791

State File No. ....

FILED OCT. 8 - 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 544 Registrar's No. 2228

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>                      |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> |   |
| b. CITY OR TOWN <u>Kirkwood</u>                                      | c. LENGTH OF STAY (in this place township) <u>27yrs</u> | c. CITY OR TOWN <u>Kirkwood</u>   | 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 <u>Res. Geyer &amp; Rott</u> |   | e. STREET ADDRESS (If rural, give location) <u>Geyer &amp; Rott Rds.</u>  |   |

|  |   |   |  |
|--|---|---|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Clara</u>   | b. (Middle) <u>Parker</u>                     | c. (Last) <u>Burrows</u>  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Sept. 23, 1955</u> |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>                     | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>     | 8. DATE OF BIRTH <u>March 11, 1877</u>                         |
| 9. AGE (In years last birthday) <u>78yrs</u>   |   | 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) <u>housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Monticello, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                        |

|                                       |  |  |
|---------------------------------------|--|--|
| 13a. FATHER'S NAME <u>John Parker</u> | 13b. MOTHER'S MAIDEN NAME <u>Roberts</u> | 14. NAME OF HUSBAND OR WIFE <u>Dr. G. W. Burrows</u> |
|---------------------------------------|--|--|

|  |                                     |   |                                      |
|--|-------------------------------------|---|--------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Gene Patchin</u> | ADDRESS <u>Geyer &amp; Rott Rds.</u> |
|--|-------------------------------------|---|--------------------------------------|

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|---|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma. Metastases to neck</u><br><br>ANTECEDENT CAUSES<br><u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u><br>DUE TO (b) <u>Carcinoma of uterine Cervix</u><br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br><u>Sclerosis of Coronary Arteries</u><br>Conditions contributing to the death but not related to the disease or condition causing death. |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 yrs.</u>                                   |
| 19a. DATE OF OPERATION _____  | 19b. MAJOR FINDINGS OF OPERATION _____  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" 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 May 18, 1954, to Sept. 23, 1955, that I last saw the deceased alive on Sept. 18, 1955, and that death occurred at 7:00P m., from the causes and on the date stated above.

|   |  |                                 |
|---|--|---------------------------------|
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____ | 23b. ADDRESS <u>19 E. Lockwood Ave. Webster Groves 19, Mo.</u> | 23c. DATE SIGNED <u>9-24-55</u> |
|---|--|---------------------------------|

|   |                                 |  |   |
|---|---------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Sept. 26, 1955</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u> |
|---|---------------------------------|--|---|

|   |  |  |                                   |
|---|--|--|-----------------------------------|
| DATE REC'D BY LOCAL REG. <u>9/26/55</u> | REGISTRAR'S SIGNATURE <u>[Signature]</u> | 5. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | ADDRESS <u>4 Sons 6175 Delmar</u> |
|---|--|--|-----------------------------------|

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

Dr H. A Goodrich  
19 E. Lockwood  
Wo 2-3200  
2-4

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 *H. E. Morris*.....

Licensed Embalmer No. *336*

P. O. Address *St. Louis*

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.