

FILED APR 6 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

10503

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3189	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer S. Phillips Hosp				d. STREET ADDRESS (If rural, give location) 1730 Division			
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) _____		c. (Last) Burnes		4. DATE OF DEATH (Month) (Day) (Year) 3-28-56	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Aug 10, 1900	
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement worker		10b. KIND OF BUSINESS OR INDUSTRY Cement work		11. BIRTHPLACE (City and State or Foreign Country) Thess, Miss	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME John Burnes		13b. MOTHER'S MAIDEN NAME Fennie Golden		14. NAME OF HUSBAND OR WIFE Beatrice Burnes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Beatrice Burnes 1730 Division			
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) Cerebro Vascular Accident 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.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 331x				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) _____			
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at HOSA m. , from the causes and on the date stated above.							
23a. SIGNATURE (Name and title) Deputy Registrar				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 3/29/56	
24. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-2-56		24c. NAME OF CEMETERY OR CREMATORY Cathedral		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REG. MAR 29 1956		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS G.H. Burks 3506 Franklin			

(Licensed Embalmer's Statement on Reverse Side)

PRINT 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 Gerard H. Pannister

Licensed Embalmer No. 4523

P. O. Address 3880 Boston

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

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