

Health, Welfare, Public Service
 300
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 diseases in Part I must be causally related. Coroner cannot certify to death due to natural causes. All symptoms with be listed. ATTENTION: Coroner's name and number are not to be entered in Part I unless they are causally related. Coroner cannot certify to death due to natural causes. All symptoms with be listed. ATTENTION: Coroner's name and number are not to be entered in Part I unless they are causally related. Coroner cannot certify to death due to natural causes. All symptoms with be listed. ATTENTION: Coroner's name and number are not to be entered in Part I unless they are causally related.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

57023040
 STATE FILE NUMBER

FILED JUL 1 1957

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 1443

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>University City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6633 Kingsbury</u>			Length of stay in 1b <u>years</u>	d. STREET (If outside, give location) ADDRESS <u>6633 Kingsbury</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ZUMA</u> Middle <u>BURKHOLDER.</u> Last <u>SANDERS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6th</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 2nd, 1883.</u>		9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife.</u>		11. BIRTHPLACE (City and state or country) <u>Pike County, Missouri.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert James Burkholder.</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Nunn.</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>unk.</u>	17. INFORMANT Address <u>Miss Anne E. Sanders 6633 Kingsbury</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Coronary arteriosclerosis</u>				<u>10 yrs</u>	
		DUE TO (c) <u>General arteriosclerosis</u>				<u>10+ yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>1948</u> to <u>June 6, 1957</u> and last saw her/him alive on <u>6-6-57</u> . Death occurred at <u>10:45 a m</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Ad Jean M.D.</u>				22b. ADDRESS <u>4500 W. Pine St Louis</u>		22c. DATE SIGNED <u>6-6-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>6/8/1957.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory.</u>		23d. LOCATION (City, town, or county) (State) <u>7800 St. Charles Road.</u>		
24. FUNERAL DIRECTOR <u>C. R. Lupton & Sons 7233 Delmar</u>			25. DATE RECD. BY LOCAL REG. <u>6-7-57</u>		26. REGISTRAR'S SIGNATURE <u>Hebe R. Donkey</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Clarence H. Murray*

Licensed Embalmer No. *701*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
(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.