

XC- 525190  
SL- 14094

FILED FEB 6 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2727

STATE FILE NUMBER

Registration District No. 318

318

Primary Registration District No. 1003

1003

Registrar's No. 887

887

300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST LOUIS</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>VET ADM HOSPITAL</u>		Length of stay in lb <u>33 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>207 BOWEN</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>A</u> Last <u>BURNS</u>				4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>58</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-4-85</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (City and state or country) <u>MODOC ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>BAZIL K BURNS</u>			13b. MOTHER'S MAIDEN NAME <u>MARY WHITE</u>			14. NAME OF HUSBAND OR WIFE <u>DIVORCED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WW-1</u>		16. SOCIAL SECURITY NO. <u>497-20-3494</u>		17. INFORMANT Address <u>VA HOSP RECORDS 915 N GRAND ST LOUIS MO.</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>ALVEOLAR CARCINOMA OF BOTH LUNGS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>-</u>	
						DUE TO (c) <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>LARGE GASTRIC ULCER</u>						19. WAS AUTOPSY PERFORMED? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>1621</u>					
20c. TIME OF INJURY Hour <u>12:45</u> Month <u>22</u> Day <u>57</u> Year <u>58</u> a.m. p.m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <u>VA</u>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. attended the deceased from <u>12-22-57</u> to <u>1-24-58</u> and last saw <u>alive</u> on <u>1-24-58</u> Death occurred at <u>12:45 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>H. Westphaelinger, D.</u>				22b. ADDRESS <u>VAH. ST. LOUIS, MO.</u>		22c. DATE SIGNED <u>1-24-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEM.</u>		23d. LOCATION (City, town, or country) (State) <u>JEFFERSON BRKS. MO</u>	
24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>JAN 24 58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith Mo</u>	

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. 4347  
P. O. Address 2906 Brown

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.