

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022745  
STATE FILE NUMBER  
Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registr<sup>2</sup> No. 5508

FILED JUL 2 1959

|  |                           |   |  |
|--|---------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo. b. COUNTY   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis   |                           | c. CITY OR TOWN St. Louis   |  |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                           | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION Faith Hospital  |                           | d. STREET ADDRESS (If outside, give location)<br>1805 Gravois   |  |
| Length of stay in lb   |                           | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>Edith G. Burian  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>June 8, 1959         |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>1/26/1916                              |
| 9. AGE (In years last birthday)<br>43  |                           | 9. AGE (In years) IF UNDER 1 YEAR<br>Months Days Hours Min.   | 10. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                           | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br>Sullivan Mo. |
| 13a. FATHER'S NAME<br>Green Stroup   |                           | 13b. MOTHER'S MAIDEN NAME<br>Hattie Campbell  | 14. NAME OF HUSBAND OR WIFE<br>Edward                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, No or unknown) (If yes, give war or dates of service)<br>No  |                           | 16. SOCIAL SECURITY NO.   | 17. INFORMANT Address<br>Edward Burian 1805 Gravois        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____<br>DUE TO (c) <u>151X</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |                           |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u>          |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |   |  |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>Hour Month, Day, Year<br>a.m. p.m.  |                           |   |  |
| 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>6/10/58</u> to <u>6/8/59</u> and last saw her alive on <u>6/8/59</u><br>Death occurred at <u>1:30 A. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |   |  |
| 22a. SIGNATURE (Name or title)<br><u>Max A. Franklin M.D.</u>  |                           | 22b. ADDRESS<br><u>6344 Grand</u>   |  |
| 22c. DATE SIGNED<br><u>6/9/59</u>  |                           |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |                           | 23b. DATE<br><u>6/10/59</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lakewood Park</u>   |                           | 23d. LOCATION (City, town, or county) (State)<br><u>County Mo.</u>  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Moydell Funeral Home 1926 Allen</u>   |                           | 25. DATE RECD. BY LOCAL REG.<br><u>JUN 9 '59</u>  |  |
| 26. REGISTRAR'S SIGNATURE<br><u>Roan Smith, M.D.</u>   |                           |   |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Halley J. Joella Jr* .....  
Licensed Embalmer No. *4950* .....  
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.