

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		Length of stay in 1b	c. CITY OR TOWN Saint Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4939 Maffitt Place		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4939 Maffitt Place
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN S. BURNS			4. DATE OF DEATH Month Day Year December 19, 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/22/82	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Private Family	11. BIRTHPLACE (City and state or country) Bovina, Miss.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Henry Burns		13b. MOTHER'S MAIDEN NAME Maby Hagans		14. NAME OF HUSBAND OR WIFE Mabel Burns	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mabel Burns, 4939 Maffitt Place	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 5 days
IMMEDIATE CAUSE (a) mesenteric thrombosis Mesehteric Thrombosis			Indeterminate
DUE TO (b) arteriosclerosis, generalized Arteriosclerosis, generalized			
DUE TO (c) 4500H			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) dissecting aneurysm of aorta Dissecting aneurysm of aorta, prostate			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 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 September 19, 1960 to Dec 19, 1960 and last saw him alive on Dec 19, 1960
Death occurred at 1:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Edw. B. Williams Jr. M.D. M.D.	(Degree or title)	22b. ADDRESS 2801 N. Taylor	22c. DATE SIGNED 12-22-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/23/60	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) St. Louis Co., Mo.

24. FUNERAL DIRECTOR Charles J. Gates, 4107 Finney	25. DATE RECD. BY LOCAL REG. DEC 22 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Rayton Swan*

Licensed Embalmer No. 4580

P. O. Address 4107 Finr

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