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2181-61-010543

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED VS MAR 16 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>St. Louis</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i> | | Length of stay-in 1b. | c. CITY OR TOWN <i>Vinita Terrace</i> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Jewish Hospital</i> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <i>7924 Page Avenue</i> |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First <i>Forrest</i> Middle <i>Quinn</i> Last <i>Burton</i> | | | 4. DATE OF DEATH Month <i>March</i> Day <i>4</i> Year <i>1961</i> | |
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|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|--|
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>8/26/04</i> | 9. AGE (last birthday) <i>56</i> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>Meyer Pntg Co.</i> | 11. BIRTHPLACE (City and state or country) <i>St. Louis, Missouri</i> | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> |
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| 13a. FATHER'S NAME <i>James Burton</i> | 13b. MOTHER'S MAIDEN NAME <i>Anna Quinn</i> | 14. NAME OF HUSBAND OR WIFE <i>Vera Burton</i> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i> | 16. SOCIAL SECURITY NO. <i>none</i> | 17. INFORMANT <i>Mrs Vera Burton 7924 Page Avenue</i> | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Arteriosclerosis</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>Sudden death.</i> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) <i>420.1</i> | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>None</i> | 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 |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) |
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|---|------------------|
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year |
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|--|--|------------------------------|--------|-------|
| 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 *Sept 1955*, to *March 4, 1961* and last saw him alive on *May 15, 1958*
Death occurred at *3:00* *A* m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <i>Charles Silverberg M.D.</i> | 22b. ADDRESS <i>462 N. Taylor Ave.</i> | 22c. DATE SIGNED <i>3/4/61</i> |
|--|---|-----------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i> | 23b. DATE <i>March 6, 1961</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove Cemetery</i> | 23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo</i> |
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| 24. FUNERAL DIRECTOR <i>Shepard Funeral Home 1167 Hamilton Ave.</i> | 25. DATE RECD. BY LOCAL REG. <i>MAR 6 1961</i> | 26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i> |
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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 18 1967

Dr. Schindler
9901 Harris
J-5.

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,

Dr. Schindler, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Lawrence O. Deering

Licensed Embalmer No. 4979

P. O. Address St. Louis, Mo

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.