

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-046141**

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12244 STATE FILE NUMBER

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

**FILED JAN 5 1962**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>	Length of stay in lb <b>63 years</b>	c. CITY OR TOWN <b>University City</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>7354 Carleton</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>Whitaker</b> Last <b>Burford</b>			4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1961</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-9-1898</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <b>Supervisor Ind. Relations</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Can Co.</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	

13a. FATHER'S NAME <b>Frank Burford</b>		13b. MOTHER'S MAIDEN NAME <b>Adah Whitaker</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Hazel Kreider Burford</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>W.W. I Army</b>				17. INFORMANT Address <b>Mrs. Hazel Burford, 7354 Carleton, Zone 30</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Aneurysm (abdominal - ruptured) 24 hours  
451X

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 12/23/61 to 12/26/61 and last saw <sup>her</sup> <sub>him</sub> alive on 12-26-61.  
Death occurred at 2 9 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Alan McAfee M.D.</u>	22b. ADDRESS <u>100 N Euclid</u>	22c. DATE SIGNED <u>12/27/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-29-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Barracks Nat. Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Alexander &amp; Sons, 6175 Delmar Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 28 1961</b>	26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>
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Dr. C.A. Mc Afee  
100 N. Euclid  
Phone: FO 1-1385

In Office 1:30 to 2:00 P.M. Tues. - Also same for Wed.

JAN 9 1962

**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 jos E McCulloch

Licensed Embalmer No. 2460  
P. O. Address 4175 RLM

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.