

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-024466

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6162** STATE FILE NUMBER

**FILED JUL 2 1962**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in (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>Luthern Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>3961 Delor</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA M BURNS</b>			4. DATE OF DEATH <b>6-20-1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-25-1890</b>
9. AGE (last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Andrew Burns</b>	
13b. MOTHER'S MAIDEN NAME <b>Katherine Gartland</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give branch or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Winifred Lamping 3961 Delore</b>		Address	
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>Cerebral Hemorrhage</i> DUE TO (b) <i>Fracture Left Femur</i> DUE TO (c) <i>Chronic Myocarditis</i> 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. <b>904021</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Fell at home</b>	
20c. TIME OF INJURY <b>10:30 AM June 20/62</b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home 6/20/62</b>	
20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo.</b>		COUNTY STATE	
21. I attended the deceased from <b>6/20/62</b> to <b>6/20/62</b> and last saw her alive on <b>6/20/62</b> . Death occurred at <b>6:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>W. R. Smith</i>		22b. ADDRESS <b>4924 LeBaron</b>	
22c. DATE SIGNED <b>6/21/62</b>		22d. CITY, TOWN, OR COUNTY (State)	
23a. BURIAL, CREMATION, REQUIEM (Specify) <b>Burial</b>		23b. DATE <b>6-23-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cem.</b>		23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>	
24. FUNERAL DIRECTOR <b>Wingermuehle 3819 So Grand Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 21 1962</b>	
26. REGISTRAR'S SIGNATURE <i>W. R. Smith, M.D.</i>			

USE BLACK INK OR TYPEWRITER RIBBON

**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 George J. King Lemmick

Licensed Embalmer No. 4651

P. O. Address Blom 18th

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.