

**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
 DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-035989  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8950**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		1. PLACE OF DEATH b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b <b>8 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>		c. CITY OR TOWN <b>East St. Louis, Illinois</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>BARNES HOSPITAL</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1027 Bond Avenue</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GENNIE NMN BURGAGE</b>			First Middle Last			4. DATE OF DEATH <b>SEPTEMBER 13 1962</b>			Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>9/3/1914</b>		9. AGE (last birthday) <b>48</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Louisville, Mississippi</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			
13a. FATHER'S NAME <b>JESSE HOLMES</b>				13b. MOTHER'S MAIDEN NAME <b>LEILA HARDIN</b>				14. NAME OF HUSBAND OR WIFE <b>NONE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, pp. or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>E. St. Louis,</b> <b>Rosemary Smith, 1027 Bond Avenue, Illinois</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) <b>RHEUMATIC HEART DISEASE</b>										INTERVAL BETWEEN ONSET AND DEATH <b>30 YEARS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____										<b>416X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>RECURRENT PULMONARY EMBOLI</b>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 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 <b>JULY 2, 1950</b> to <b>SEPT 13, 1962</b> and last saw her/him alive on <b>SEPT. 13, 1962</b> Death occurred at <b>10:15 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>C. D. Demillon, M.D.</i> (Degree or title)						22b. ADDRESS <b>BARNES HOSPITAL</b>			22c. DATE SIGNED <b>9/14/62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/20/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Gardens of Memory</b>		23d. LOCATION (City, town, or county) <b>Stokey Township, Illinois</b>		(State)			
24. FUNERAL DIRECTOR <i>Marion B. Blair</i>		ADDRESS <b>2114 Missouri Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 17 1962</b>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>					
24. ADDRESS <b>E. St. Louis, Illinois</b>											

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 Gayton Swan

Licensed Embalmer No. 4580

P. O. Address 2114 Mo. Ave.  
E. St. Louis, Ill.

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.