

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D NOV 16 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

34176
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City..... St. Louis, Mo. (d) Street No..... Christian Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. 14 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah Francis Burnett

(a) Residence, No. St. N.R. Butler ~~Mississippi~~ Illinois
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George Burnett
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 18/1862
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
75 10 1
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) Sept. 1938 11. Total time (years) spent in this occupation 50 yrs.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Butler ~~Mississippi~~ Illinois

FATHER 13. NAME James A. Suits
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Pennsylvania

MOTHER 15. MAIDEN NAME Unknown Thornton
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Pennsylvania

17. INFORMANT John Burnett
(ADDRESS) 5865A. Romaine

18. BURIAL, CREMATION, OR REMOVAL PLACE Hillsboro, Ill. DATE Oct. 22/1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe, Inc.
4700 Washington Blvd

20. FILED OCT 21 1938 J. Bredeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 19/1938

22. I HEREBY CERTIFY, That I attended deceased from 10-10, 1938, to 10-19, 1938
I last saw h. aw alive on 10-19, 1938 Death is said to have occurred on the date stated above, at 6:45 p
The principal cause of death and related causes of importance were as follows:

Diabetes mellitus

57

Other contributory causes of importance: Chr. endocarditis
Chr. interstitial nephritis

Name of operation..... Date of.....
What test confirmed diagnosis? apan Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) W. H. H. H. H. H. M.D.
(Address) 514 N. Union Blvd

OCT 31 1944

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed *J. B. Sullivan*

Licensed Embalmer No. *1122*

P. O. Address _____

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 this body is not embalmed, above space should be left blank.