

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 MAY 10 1939

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

13475
Do not use this space.

3817

1. PLACE OF DEATH

(a) County..... Registration District No..... **791**
(b) Township..... Primary Registration District No.....
(c) City..... **St. Louis** (d) Street No..... **Homer Phillips 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 **22** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **652 Nellie Burns**

(a) Residence, No. **3037 Madison** St. **30** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **C** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Bill Burns**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **June 10, 1897**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
41 10 10

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **housework**
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)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Arkansas**FATHER 13. NAME **Miles Ferrell**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **unknown**MOTHER 15. MAIDEN NAME **Rachel Gates**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **unknown**17. INFORMANT (ADDRESS) **Evelyn Hilliard**
2601 N Whittier18. BURIAL, CREMATION, OR REMOVAL PLACE **Aquaria Ave** DATE **4-25-39**19. FUNERAL DIRECTOR (NAME) (ADDRESS) **People and Co.**
3100 Franklin Ave.20. FILED **APR 24 1939** **J. D. Budak** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April 20, 1939**22. I HEREBY CERTIFY, That I attended deceased from **April 7, 1939, to April 20, 1939**I last saw her alive on **April 20, 1939** Death is said to have occurred on the date stated above, at **8:15a.m.**

The principal cause of death and related causes of importance were as follows:

Lobar pneumoniaDate of onset
4/7/39

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis **clinical** Was there an autopsy? **yes**

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?

If so, specify **Yes**(Signed) **H. J. Lippman**, M. D.(Address) **2601 N Whittier**

