

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

16877  
State File No. \_\_\_\_\_  
Registrar's No. **4355**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
City Hospital, #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 Days  
(Specify whether \_\_\_\_\_)  
In this community Unknown  
years, months or days)

3. (a) PRINT FULL NAME Patrick Burns **652**

3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years ABOUT 65 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Unknown  
(City, town, or county) (State or foreign country)

10. Usual occupation Unknown

11. Industry or business Unknown

12. Name Unknown

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Morrison

(b) Address City Hospital, #1

17. (a) BURIAL (b) Date thereof 5/16/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Walter Ford

(b) Address 1416 N. Taylor ave

19. (a) MAY 16 1940 (b) J. H. [Signature]  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis **24**  
(If outside city or town limits, write "RURAL")  
(d) Street No. Shack #87, Foot of President St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25,  
year 1940 hour 12:25 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from April 15, 1940, to April 25, 1940;  
that I last saw him alive on April 25, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 6 days

Due to arteriosclerosis year

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 87

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Walter Ford (M. D. or other) \_\_\_\_\_

Address 1515 Lafayette 10/25/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

*Raymond E. Burke*

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

*city license #1,80* Signed *Raymond E. Gehlke*

Licensed Embalmer No. *3985*

P. O. Address *St. Louis, Mo*

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.