

4-13-40
5-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 25 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23749
Registrar's No. 6194

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 6 Days
(Specify whether
In this community 64 yrs. 4 mos. 11 das
years, months or days)

3. (a) PRINT FULL NAME Nellie Burgoyne 625

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Walter Burgoyne 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar. 11, 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>4</u>	<u>11</u>	_____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name Michael Baker 5

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

14. Maiden name Delia Gibbons

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

16. (a) Informant Mrs Geo. Roach

(b) Address 6525 Clayton Ave

17. (a) Burial (b) Date thereof July 25, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Boehart Boehart
(b) Address 2 228 St. Louis Ave

19. (a) JUL 24 1940 (b) J. F. Bredbeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 20
(If outside city or town limits, write "RURAL")
(d) Street No. 2715 Baldwin Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22,
year 1940 hour 7:08 minute _____ P. M.

21. I hereby certify that I attended the deceased from July 17, 19 40 to July 22, 19 40
that I last saw her alive on July 22, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Ovary (with metastases)

Due to arteriosclerosis, generalized.
Due to Chronic cholecystitis.

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

Major findings: Of operations 49
Of autopsy as above.

Duration _____
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 James P. Muehle (M. D. or other) _____
Address 1545 Lafayette Date signed 7/23/40

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

MOTHER FATHER

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 *Charles Goodhead*

Licensed Embalmer No. *2777*

P. O. Address *2228 St Louis Ave*

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, fact should be so stated above.