REC SEP 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27094

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 6990

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.

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution April 11, 1940. 18yrs. (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis.

(c) City or town St. Louis, 13
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? American. years.

3. (a) PRINT FULL NAME John Burns. 652

3. (b) If veteran, name war Unknown.

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race Colored

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lena Burns.

6. (c) Age of husband or wife if alive UNK years

7. Birth date of deceased (Month) (Day) (Year) 1884

8. AGE: Years	Months	Days	If less than one day
56	X	X	hr. min.

9. Birthplace Ga. (City, town, or county) 1 (State or foreign country)

10. Usual occupation No Occupation

11. Industry or business X

FATHER
12. Name Martin Burns
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Dorothy Potts
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant's own signature E. Molony

(b) Address 5800 Arsenal St.

17. (a) Washington Park (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1940. (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park.

18. (a) Signature of funeral director Wright's Funeral Home.

(b) Address 3100 Easton Ave.

19. (a) AUG 19 1940 (Date received local registrar) (b) J. F. [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15, year 1940 hour 6:55 minute a. M.

21. I hereby certify that I attended the deceased from April 11, 1940, to August 15, 1940; that I last saw him alive on August 15, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative heart disease

Due to

Due to

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

Major findings:
Of operations

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 R. W. Maxwell (M. D. or other)

Address Isolation Hospital Date signed 8/15/40

(Licensed Embalmer's Statement on Reverse Side)

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 Robert H. Powell.

Licensed Embalmer No. 3402

P. O. Address 3100 Franklin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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