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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 30144

Registration District No. 791 (OCT 25 1940)

Primary Registration District No. 1003

Registrar's No. 7421

**1. PLACE OF DEATH:**

(a) County

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

(c) Name of hospital or institution: DePaul Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Life 1 (Specify whether years, months or days)

In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St Louis

(c) City or town Pine Lawn NER
(If outside city or town limits, write "RURAL")
0

(d) Street No. 6159 Natural Bridge Ave
(If rural, give location)

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

3. (a) PRINT FULL NAME Barbera Ann Burns

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 Single

6. (b) Name of husband or wife ---

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

7. Birth date of deceased August (Month) 31 (Day) 1940 (Year)

8. AGE: Years 0 Months 0 Days 3 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Infant 0

11. Industry or business -------- 1

FATHER
12. Name Robert Burns
13. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Betty Melton
15. Birthplace Zenia (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Robert Burns
(b) Address 6159 Natural Bridge Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4/40 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Jos. W. Clark.
(b) Address 1125 Hodiamont Ave.

19. (a) SEP 4 1940 (Date received by local registrar) (b) [illegible] (Signature of registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 3 year 1940 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from Sept. 2, 1940 to Sept. 2, 1940 that last saw her alive on Sept. 2, 1940 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Hemorrhagic disease of the newborn | 2 da |
| Due to Congenital. | |
| Cerebral hemorrhage | 2 da |
| Due to above | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy as stated above

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 J. Wistar White (M. D. or other)
Address 4500 Olive Date signed

(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 _____

Licensed Embalmer No. _____

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.**