

FILED SEP 18 1944

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2640

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 BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days (Specify whether years, months or days)
In this community 12 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison
(c) City or town Collinsville
(If outside city or town limits, write "RURAL")
(d) Street No. 403 Merrill Ave
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Everett B. Burroughs

3. (b) If veteran, name war World 1 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Leah M. Burroughs 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Jan 12th-1898
(Month) (Day) (Year)

8. AGE: Years 46 Months 7 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Superintendent of

11. Industry or business Public Schools

12. Name Arthur H Burroughs

13. Birthplace Not known Ills.
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Vogel

15. Birthplace Not known Ills.
(City, town, or county) (State or foreign country)

16. (a) Informant Leah M Burroughs

(b) Address Collinsville, Ills.

17. (a) removal (b) Date thereof 10/5/1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation xx Collinsville Ills

18. (a) Signature of funeral director Geo M. Schroppel

(b) Address Collinsville, Ills.

19. (a) SEP 5 1944 (b) J. Meddel
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3
year 1944 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from August 22, 1944 to Sept. 3, 1944 that I last saw him alive on September 3, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia
Monocytic Leukemia

Due to _____

Due to _____

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

Major findings:
Of operations _____
Of autopsy Monocytic Leukemia
Septicemia (Em. neg. rod.)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature James F. Tagge (M. D. or other) _____

Address Barnes Hospital Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

999
N.R.S.

J. H. A.

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

Geo M Schuppel

Licensed Embalmer No. 1598

P. O. Address Collinsville, Ills.

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.