

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. _____ Primary Registration District No. **1003**

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

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1527 Webster
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ella Mae Burt

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

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced child

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

7. Birth date of deceased: Sept. 26 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 03 4 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name William Burt
13. Birthplace Arkansas (City, town, or county) (State or foreign country)
14. Maiden name Erlene Wright
15. Birthplace Miss. (City, town, or county) (State or foreign country)

16. (a) Informant William Burt, Father

(b) Address Same address

17. (a) Burial (b) Date thereof 12-31-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director C. M. ...

(b) Address 2120 ...

19. (a) DEC 31 1946 (Date received local registrar) J. F. ... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 30
year 1946 hour 2 minute 55 P.M.

21. I hereby certify that I attended the deceased from 12-26 19 46, to 12-30 19 46
that I last saw her alive on Dec. 30 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchitis - acute,
Due to Anemia

Due to _____
Other conditions (include pregnancy within 3 months of death) 1/16

Major findings: Of operations _____
Of autopsy NO

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? _____

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

23. Signature Theodore Blevins (M. D. or other) _____
Address 2601 N. Whittier Date signed 12/30/46

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.....

Clark Yarnall

Licensed Embalmer No..... *33710*

P. O. Address..... *S. J. Jones*

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.