

No. 2  
-12-45  
-17-39  
X47070

**FILED APR 14 1947**  
318

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
(a) County St. Louis  
(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 17 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

**3. (a) PRINT FULL NAME** Addie Burch  
**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** married  
**6. (b) Name of husband or wife** Walter Burch **6. (c) Age of husband or wife if alive** 59 years  
**7. Birth date of deceased** Aug 10 - 1990  
(Month) (Day) (Year)

**8. AGE:**  
Years 56 Months 7 Days 20  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace:** St. Louis (City, town, or county) Mo (State or foreign country)

**10. Usual occupation:** House wife

**11. Industry or business:** \_\_\_\_\_

**12. Name:** Siles Davison

**13. Birthplace:** Union (City, town, or county) Mo (State or foreign country)

**14. Maiden name:** Opheila Lee

**15. Birthplace:** St. Louis (City, town, or county) Mo (State or foreign country)

**16. (a) Informant:** Walter Burch

**(b) Address:** 2332 Papin

**17. (a) (Burial, cremation, or removal):** Burial **(b) Date thereof:** 4-5-47  
(Month) (Day) (Year)

**(c) Place: burial or cremation:** Washington Park

**18. (a) Signature of funeral director:** J. F. Bredbeck

**(b) Address:** 2746 Chouteau  
**19. (a) (Date received local registrar):** APR 2 1947 **(b) (Registrar's signature):** J. F. Bredbeck

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County 000  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 2332 Papin (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Mar. day 30  
year 1947 hour 9 minute 25 P.M.  
**21. I hereby certify that I attended the deceased from** 3-30  
1947 to 3-30 1947  
that I last saw her alive on Mar. 30 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration Undet.  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions None  
(include pregnancy within 3 months of death)

**PHYSICIAN**  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Yes  
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)  
(c) Means of injury (1)  
**23. Signature:** Edw. B. Williams (M. D. or other)  
Address 2601 N. Whittier Date signed 4/2/47

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

MOTHER FATHER

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**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. *2698*

P. O. Address *2769 Chouteau*

**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.