

No. 300  
4-10-47  
7-5-17-39  
I 3906

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **113925**  
**4210**

FILED MAY 11 1948

Registration District No. **318** Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**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:  
**5126 ADELMAR BLV. /**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. \_\_\_\_\_  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo.** (b) County \_\_\_\_\_  
 (c) City or town **ST. LOUIS** **17**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **5126 ADELMAR** **7**  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **KATE BURTON**

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

4. Sex **FE /** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **W. 2**

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

7. Birth date of deceased **APRIL 19, 1869**  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **May** day **2**  
 year **1948** hour **11** minute \_\_\_\_\_ p.m.

21. I hereby certify that I attended the deceased from **July 3, 1948** to **May 2, 1948**  
 that I last saw her alive on **7/31/48** and that death occurred on the date and hour stated above.

8. AGE: Years **79** ~~80~~ -Months **0** Days **13** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **NIL**

Immediate cause of death **Ac Cardiac Failure** **3D**

Due to **Cardio Renal** **1 yr.**  
**Hypertensive disease**

Due to **Chronic Myocarditis**  
**Heart failure** **1 yr.**

Other conditions **arterial sclerosis**  
(Include pregnancy within 3 months of death)

**MOTHER FATHER**

11. Industry or business \_\_\_\_\_

12. Name **UNK KEENAN**

13. Birthplace **UNK UNK**  
(City, town, or county) (State or foreign country)

14. Maiden name **UNK UNK**

15. Birthplace **UNK UNK**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Christine Eis**  
 (b) Address **5126 Delmar Blv.**

17. (a) **BURIAL** (b) Date thereof **MAY 5-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY C.**

18. (a) Signature of funeral director **E. J. Schurr**  
 (b) Address **3125 Lafayette av.**

19. (a) **MAY 4 1948** (b) **J. F. Bredeck**  
(Date received local registrar) (Registrar's signature)

Major findings: **no**

Of operations \_\_\_\_\_

Of autopsy **no**

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? \_\_\_\_\_

Where at work? \_\_\_\_\_  
(Specify type of place)

Means of injury **George J. Meloy**  
**3903 Olive**

23. Signature **George J. Meloy** (M.D. or Ch.D.)  
 Address **3903 Olive** Date signed **5/4/48**

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

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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 John B. Vallin

Licensed Embalmer No. 11014

P. O. Address 3125 S. Dupont

**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.**