

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 13 1948

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7690**

1. PLACE OF DEATH: **318**

(a) County.....
 (b) City or town..... **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **5 days**
(Specify whether
 In this community **Unknown**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County..... **100**
 (c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL") **17**
 (d) Street No..... **523 Market St.,**
Memorial **25** **9**
(If rural, give location)
 (e) Citizen of foreign country? **?** **0**
(Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **WILLIAM BURNS**

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

4. Sex **male** **5. Color or** **white**
race.....

6. (a) Single, widowed, married, **9 Unknown**
divorced.....

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

7. Birth date of deceased..... **Unknown**
(Month) (Day) (Year)

8. AGE: **Years** **Months** **Days** **If less than one day**
abt-50 - Unknown **hr.** **min.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **20th**
 year **1948** hour **6** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **8/15/48**
 _____, 19____, to **Aug. 20th**, 19 **48**
 that I last saw him alive on **Aug. 20th**, 19 **48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **10 days**
Lobar Pneumonia

Due to **108**

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....
 Of autopsy.....

PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

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

10. Usual occupation **Unknown**

11. Industry or business

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **M. Renard**
 (b) Address **St. Louis City Hospital**
Anatomical Board

17. (a) **Anatomical Board** **(b) Date thereof** **AUG 31 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rowland Mortuary Service**

18. (a) Signature of funeral director **4104 Manchester Ave.**
AUG 31 1948 **J. F. Medeck**
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury

23. Signature **1515 Lafayette** **8/21/48**
Gae H. Nardin **Thad.**
Address Date signed

JAN 27 1958

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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.