

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived—If institution: residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| c. LENGTH OF STAY (in this place) 26 Days | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHRONIC HOSPITAL | | e. STREET ADDRESS (If rural, give location) 3316 Park Avenue | |

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| 3. NAME OF DECEASED (Type or Print) ORBIE BROWN BURTON | | | 4. DATE OF DEATH (Month) (Day) (Year) 6 5 1954 | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single | |
| 8. DATE OF BIRTH January 19, 1906 | | 9. AGE (In years last birthday) 48 | | 10. IF UNDER 14 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not employed | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) Kentucky | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |

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|-----------------------------------|--|-----------------------------------|--|------------------------------------|--|
| 13a. FATHER'S NAME Wallace Burton | | 13b. MOTHER'S MAIDEN NAME Maude ? | | 14. NAME OF HUSBAND OR WIFE Single | |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME Hospital Records ADDRESS | |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Bronchiogenic Carcinoma of Lung | | INTERVAL BETWEEN ONSET AND DEATH years | |
| *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | |
| | | DUE TO (b) | | | |
| | | DUE TO (c) | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 1162 X | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from May 11, 1954, to June 5, 1954, that I last saw the deceased alive on June 5, 1954, and that death occurred at 4:20 A.M., from the causes and on the date stated above.

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| 23a. SIGNATURE George Esker M.D. | | 23b. ADDRESS 5600 Arsenal St. | | 23c. DATE SIGNED 6/5/54 | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 6-5-54 | | 24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery | |
| | | | | 24d. LOCATION (City, town, or county) (State) West Frankfort Ill | |

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| DATE REC'D BY LOCAL REG. JUN 7 1954 | | REGISTRAR'S SIGNATURE Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Union Funeral Home West Frankfort Ill | |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Ronald D. York*.....

Licensed Embalmer No. *391*

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.