

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24336

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7109**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b>		c. CITY OR TOWN <b>St Louis</b>	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 <b>Missouri Pacific</b>		e. STREET ADDRESS (If rural, give location) <b>4028a Lafayette</b> <b>2179</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Fred</b> b. (Middle) <b>Walthall</b> c. (Last) <b>Burch</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July 31 1954</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Apr 18 1881</b>
9. AGE (In years last birthday) <b>73</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Bowling Green Ky</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	12. CITIZEN OF WHAT COUNTRY? <b>1</b>
13a. FATHER'S NAME <b>John Burch</b>		13b. MOTHER'S MAIDEN NAME <b>Columbia Walthall</b>	14. NAME OF HUSBAND OR WIFE <b>Frances Burch</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Frances Burch 4028a Lafayette</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Nephrosis; Surgical removal of spleen; traumatic following fall down steps at home July 28, 1954</b> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <b>about 11:15 am</b> Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>Accident</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St Louis Mo</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>July 28 54 16:15</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>E9000</b>	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. <b>21</b>			
23a. SIGNATURE <b>Patrick F. Taylor Coroner</b> (Degree or title)		23b. ADDRESS <b>1300 Clark</b>	23c. DATE SIGNED <b>AUG 1 1954</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Aug 1 54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>City</b>	24d. LOCATION (City, town, or county) (State) <b>Bowling Green Ky</b>
DATE REC'D BY LOCAL REG. <b>AUG 2 1954</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MO</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>E.J. Schmur 3125 Lafayette</b>	

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 *Thomas R. Jencarek*.....

Licensed Embalmer No. *3793*.....

P. O. Address *3125 Lafayette*.....

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.