

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **42238**
Registrar's No. **10520**

| | | | | | | | | | | |
|---|--|---|---|--|--|---|-----------------------------------|---|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 10520 | | | | |
| 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. LENGTH OF STAY (In this place) _____ | | c. CITY OR TOWN St. Louis | | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Marys Infirmary | | | | e. STREET ADDRESS (If rural, give location) 2832 Dayton Street | | | | 21 2219 | | |
| 3. NAME OF DECEASED (Type or Print) | | | a. (First) Robert | | b. (Middle) Leo | | c. (Last) Burgess | | | |
| 4. DATE OF DEATH | | (Month) 11 | | (Day) 14 | | (Year) 54 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH 10-19-1898 | | 9. AGE (In years last birthday) 56 | | |
| | | | | | | | | 10. IF UNDER 24 HRS. Hours Min. 15 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Handler | | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | | 11. BIRTHPLACE (City and State or Foreign Country) Mississippi | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME George Burgess | | | 13b. MOTHER'S MAIDEN NAME Carrie Murphy | | | 14. NAME OF HUSBAND OR WIFE Louise Burgess | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) WW I | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT'S SIGNATURE OR NAME Louise Burgess | | | ADDRESS 2832 Dayton Street | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia | | | | | | | | |
| | | ANTECEDENT CAUSES | | | | | | | | |
| | | *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | | | | | | | | |
| | | 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. | | | | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 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) _____ | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 490X | | | | | | |
| 22. I hereby certify that I attended the deceased from Nov 12 , 19 54 , to Nov 14 , 19 54 , that I last saw the deceased alive on Nov 14 , 19 54 , and that death occurred at 11 m., from the causes and on the date stated above. | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) Walter A. Younger MD | | | | 23b. ADDRESS 2337 Market St | | | 23c. DATE SIGNED 11/15/54 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 11-22-54 | | 24c. NAME OF CEMETERY OR CREMATORY National | | 24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Missouri | | | | |
| DATE REC'D BY LOCAL REG. NOV 19 1954 | | REGISTRAR'S SIGNATURE J. Carl Smith MD | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St. | | | | | |
| (Licensed Embalmer's Statement on Reverse Side) | | | | | | | | | | |

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... *Arthur E. Perkins*

Licensed Embalmer No. *4198*

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.