

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6044

1442

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY New Madrid	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Portageville	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place)		STREET ADDRESS (If rural, give location) 0721	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL 0			

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) NMN	c. (Last) Burns	4. DATE OF DEATH (Month) (Day) (Year) Feb. 9, 1955
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) ab.62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Texas	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Pearl
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ==	16. SOCIAL SECURITY NO. ==	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital Records=Barnes Hospital

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coccidiomycosis		
	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.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 133x

22. I hereby certify that I attended the deceased from July 29, 1954, to Feb. 9, 1955, that I last saw the deceased alive on Feb. 9, 1955, and that death occurred at 10:00P., from the causes and on the date stated above.

23a. SIGNATURE <i>E. Vermillion, M.D.</i>	(Degree or title) M. D. 0	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 2/11/55
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2-28-55	24c. NAME OF CEMETERY OR CREMATORY Anatomical Boars	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. FEB 16 1955	REGISTRAR'S SIGNATURE <i>J. Cash Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>McRawland</i>	ADDRESS 4104 Manchester
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.