

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18506**
Registrar's No. **5037**

FILED JUN 7 1957

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

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 50 yrs		d. STREET ADDRESS (If rural, give location) 1001 5445 Page Blvd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 78 N.O.A. De Paul Hospital			

3. NAME OF DECEASED (Type or Print) Mrs Lucille E. Burns			4. DATE OF DEATH (Month) (Day) (Year) 5 28 57		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, <u>WIDOWED</u> , DIVORCED (Specify)	8. DATE OF BIRTH Dec. 19, 1892	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR: Months 5 Days 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pvt. Sec. American Retailers		10b. KIND OF BUSINESS OR INDUSTRY Retailers		11. BIRTHPLACE (State or foreign country) Waterloo, ILL.	12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Peter Lowry	13b. MOTHER'S MAIDEN NAME Mary Ann Shields	13c. NAME OF HUSBAND OR WIFE Leo Thomas Burns
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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) No	16. SOCIAL SECURITY NO. 488-01-2706	17. INFORMANT'S SIGNATURE OR NAME Mr. Gene Lowry	ADDRESS 5445 Page Blvd
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral aneurysm		
	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. 452x			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 10, 1952**, to **May 28, 1957**, that I last saw the deceased alive on **May 22, 1957**, and that death occurred at **10:30 a** m., from the causes and on the date stated above.

23a. SIGNATURE Plummer Kace M.D.	23b. ADDRESS 1117 N Grand Ave	23c. DATE SIGNED May 29, 1957
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE May 31, 1957	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. MAY 29 57	REGISTRAR'S SIGNATURE J. Earl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly	ADDRESS 3840 Wendell Blvd.
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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
Student Embalmer

Signed _____

Licensed Embalmer No. 4699

P. O. Address 3840 Lindell

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