

Health, Welfare Public Service

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-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STANDARD CERTIFICATE OF DEATH

19497

FILED MAY 20 1957

STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 531 Registrar's No. 1194

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN University City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Old Peoples			Length of stay in lb Home 4 1/2 yrs.		d. STREET ADDRESS 6600 Washington		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Nellie				First Nellie		Middle G.		Last Burrus		4. DATE OF DEATH Month May Day 7 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1885		9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Wheatland, Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME John Burrus						14. MOTHER'S MAIDEN NAME Indiana Palmer							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Christian Old Peoples Home Records							
18. CAUSE OF DEATH - [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis										INTERVAL BETWEEN ONSET AND DEATH 1 mo.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b)			
										DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE		
21. I attended the deceased from 4/2/57 to 5/2/57 and last saw her/him alive on 5/2/57 Death occurred at 5:40 pm on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE of Myers M.D.						(Degree or title)			22b. ADDRESS 607 N. Grand			22c. DATE SIGNED 5-5-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county)			(State)		
Removal			5-8-57		Local			Wheatland, Ind.					
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.						25. DATE RECD. BY LOCAL REG. 5-8-57			26. REGISTRAR'S SIGNATURE Albert B. Donk MD				

JUN 12 1957

Faint, mostly illegible text at the top of the page, possibly containing names and dates.

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 *John J. James*
Licensed Embalmer No. *41*
P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.