

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014764
STATE FILE NUMBER

FILED MAY 6 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **23601**

300
-57
3
3

| | | | |
|---|--|---|--|
| 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, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital | | Length of stay in 1b | d. STREET ADDRESS 4356 St. Ferdinand (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

| | | | | | |
|--|----------------------------------|---|--|---|--|
| 3. NAME OF DECEASED (Type or print) First Antwine Middle Last Burgett | | | 4. DATE OF DEATH Month 4 Day 9 Year 59 | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-1-36 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Factory | 11. BIRTHPLACE (City and state or country) St. Mary, Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME Antwine Burgett | | 13b. MOTHER'S MAIDEN NAME Josephine Robinson | | 14. NAME OF HUSBAND OR WIFE Laura Burgett | |

| | | | |
|--|-------------------------|--|--|
| 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. | 17. INFORMANT Address Laura Burgett 4356 St. Ferdinand | |
|--|-------------------------|--|--|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage DUE TO (b) Extra peritoneal Hemorrhage DUE TO (c) Multiple Fractures. | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not stated in the terminal disease condition given in PART I. (e.g., car operated by street car) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | | |
|--|---|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (When nature of injury in PART I or PART II of item 18.) Car operated by street car and St. Ferdinand Ave. Street. | |
| 20c. TIME OF INJURY 7:25 p.m. - 4:39 | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, etc.) 113 Street | |

| | | | |
|---|---|----------------------------|--------------------|
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20f. CITY, TOWN, OR LOCATION St. Louis Mo | COUNTY St. Louis | STATE Mo |
| 21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at 646 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |

| | | |
|---|-----------------------------------|------------------------------------|
| 22a. SIGNATURE Paul J. Simon (Degree of title) Coroner 3 | 22b. ADDRESS 1300 Clark | 22c. DATE SIGNED 4/11/59 |
|---|-----------------------------------|------------------------------------|

| | | | |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 4-13-59 | 23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery | 23d. LOCATION (City, town, or country) (State) St. Louis County, Mo. |
|---|-----------------------------|---|--|

| | | |
|--|--|--|
| 24. FUNERAL DIRECTOR ADDRESS Dement & Son 2629-31 Cole St. | 25. DATE RECD. BY LOCAL REG. APR 11 1959 | 26. REGISTRAR'S SIGNATURE Paul Smith, M.D. |
|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

CR

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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 *W. Claude Gordon*

Licensed Embalmer No. *3489*
P. O. Address *4575 Aldine*

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.