

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG. 4 1959

59-026470

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 6887** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. Length of stay in 1b _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE Missouri COUNTY _____ 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 Lutheran Hospital Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4023 Schiller Pl. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Henry Middle O. Last Burns			4. DATE OF DEATH Month July Day 24 Year 1959			
5. SEX male	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 2, 1902	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Arkansas		11. BIRTHPLACE (City and state or country) USA		
13a. FATHER'S NAME John Burns		13b. MOTHER'S MAIDEN NAME Adelaide Smith		14. NAME OF HUSBAND OR WIFE Cathleen Burns		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Cathleen Burns 4023 Schiller Pl.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelo-fibrosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Myelo-phthisic Anemia DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____		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 **February 25th., 1959** to **July 23, 1959** and last saw her/him alive on **July 23rd., 1959**
 Death occurred at **3 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>M.D. M. D.</i>	22b. ADDRESS 4717 Morganford Rd.,	22c. DATE SIGNED 7/24/59.
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 7-27-59	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park
23d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.		

24. FUNERAL DIRECTOR'S ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. JUL 24 '59	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i> <i>M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Mr W. J. Naginbach
4717 Morganford
St. Louis 1-1535

(4)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed David Lee Fossa

Licensed Embalmer No. 4243

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.