

1. PLACE OF DEATH a. COUNTY			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) St. Louis		Length of stay in 1b	c. CITY OR TOWN Mehlville St. Louis (23)		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Maternity Hosp.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5536 Dober	
3. NAME OF DECEASED (Type or print) First Middle Last Burnett			4. DATE OF DEATH Month Day Year Sept. 9 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-9-60	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min. 11 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) St. Louis Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.			13a. FATHER'S NAME Rife William Burnett		
13b. MOTHER'S MAIDEN NAME Emma Minnie Schulte			14. NAME OF HUSBAND OR WIFE none		
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. none		17. INFORMANT Mrs. Emma Burnett Address: 5536 Dober Mehlville, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYALINE MEMBRANES DUE TO (b) SUB-ARACHNOID HEMORRHAGE DUE TO (c) 760.0					INTERVAL BETWEEN ONSET AND DEATH 48 hrs
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.) HYALINE MEMBRANE			
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 Sept. 9, 1960 to Sept. 9, 1960 last saw him alive on Sept. 9, 1960 Death occurred at 4:50 P m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>G. Khatoon</i> (Degree or title) (Dr. KHATOON)			22b. ADDRESS St. Louis Maternity Hospital		22c. DATE SIGNED 9-10-60
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 9-10-60	23c. NAME OF CEMETERY OR CREMATORY St. Paul Evangelical Cem.		23d. LOCATION (City, town, or county) (State) Gerald, Missouri	
24. FUNERAL DIRECTOR E.J. Meyer F. Home Gerald, Missouri			25. DATE RECD. BY LOCAL REG. SEP 10 1960		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Not Embalmed _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed EJ Meyer _____
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.