S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 18 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23127

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7754

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2120 E. Prairie
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME John Homer Burr

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lilly Rickman Burr

6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased August (Month) 23 (Day) 1916 (Year)

8. AGE: Years 28 | Months 0 | Days 11 | If less than one day hr. min.

9. Birthplace Bonne Terre (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Truck Driver

11. Industry or business

MOTHER FATHER

12. Name Thomas Burr

13. Birthplace Ironton (City, town, or county) Missouri 0 (State or foreign country)

MOTHER

14. Maiden name Mamie Rennie

15. Birthplace Graniteville (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Lilly Burr

(b) Address 2120 E. Prairie

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-44 (Month) (Day) (Year)

(c) Place: burial or cremation Bonne Terre, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) SEP 7 1944 (Date received local registrar) (b) J. F. Bredell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 4th year 1944 hour 11 minute 55 P M.

21. I hereby certify that I attended the deceased from 9/2/44, 19, to Sept. 4th, 19 44 that I last saw him alive on Sept. 4th, 19 44 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar pneumonia	
Due to: 106	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Chronic heart disease	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Fam. Kinley (M.D. or other) M.D.
Address 1515 Lafayette Ave. Date signed 9/5/44

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed..... W Wilkinson

Licensed Embalmer No. 3573

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