

REC'D MAY 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

12758
Do not use this space.

791
1003

Registered No. 3100

1. PLACE OF DEATH Homer Phillips Hospital

(a) County 3 Registration District No. 791
(b) Township 1 Primary Registration District No. 1003
(c) City ST. LOUIS (d) Street No. en route Homer G. Phillips Hosp. St. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Thomas Burk

(a) Residence, No. 2616 Sheridan St. 21 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF UNKNOWN

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) UNKNOWN

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. About 66

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST LOUIS Missouri

FATHER 13. NAME LOUIS BURK

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Mandy Clay

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Sarah DUNKLIN 2616 Sheridan

18. BURIAL, CREMATION, OR REMOVAL PLACE Father Dickson DATE 4-4-39

19. FUNERAL DIRECTOR (ADDRESS) F. L. Garner 2824 Washington Ave.

20. FILED APR 2 1939 J. F. Biedich Local Registrar

MEDICAL CERTIFICATE OF DEATH

no attending physician

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 30 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 11:10 A.M.

The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia.

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? NO.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury see above

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

(Signed) Joseph M. Quinn M.D.
(Address) Deputy Coroner

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X12004

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____
hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____
_____ L. E. _____
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed *Arthur L. Hilliard*

Licensed Embalmer No. 3389

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.)