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No. 2  
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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

9085

791

STANDARD CERTIFICATE OF DEATH

1003

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 2495

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 #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 27 Days  
(Specify whether years, months or days)

In this community 40 yrs  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Warden Burke

3. (b) If veteran, name war NO

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

Abt 60 hr. min.

9. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name Unknown

13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant R. B. Father James

(b) Address 1207 N. 16th St.

17. (a) Burial (b) Date thereof Mar. 17, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director [Signature]

(b) Address 1138 N. 16th St.

19. (a) MAR 19 1941 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County XX  
St Louis Mo 009

(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown No Front 17  
(If rural, give location)

(e) Citizen of foreign country? Yes (Yes or No)  
If yes, name country Ireland

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15,  
year 1941 hour 5:20 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from February  
17, 1941 to March 15, 1941;

that I last saw him alive on March 15, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Pulmonary tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 1943

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address 1515 Lafayette Avenue Date signed 3/17/41

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

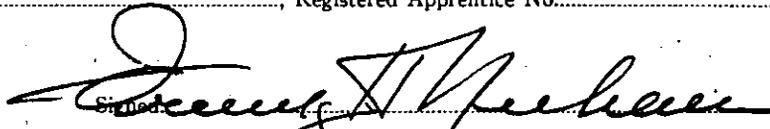
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**STATEMENT BY LICENSED EMBALMER**

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:   
Licensed Embalmer No. 2915

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.**