

FILED JUN 11 1945
Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **973**

1. PLACE OF DEATH: **St. Louis County**

(a) County **St. Louis County**

(b) City or town **Jefferson Barracks**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Veterans Administration Facility**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **Adm. Aug. 31, 1936**
(Specify whether years, months or days)

In this community **unknown**

3. (a) PRINT FULL NAME **Joseph G. BURKE**

3. (b) If veteran, name war **World War #1**

3. (c) Social Security No. **-**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced, **Widower**

6. (c) Age of husband or wife if alive, years **22, 1887**

7. Birth date of deceased: **December 22, 1887**
(Month) (Day) (Year)

8. AGE: Years **57** Months **3** Days **28** If less than one day **hr. min.**

9. Birthplace **Sligo Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business **-**

MOTHER FATHER { 12. Name **Dean Burke**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Jane Crocker**

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

16. (a) Informant **Clinical Records,**

(b) Address **Vet. Adm. Fac. Jeff. Brks. Mo.**

17. (a) **Burial** (b) Date thereof **April 20, 45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **National Cemetery**

18. (a) Signature of funeral director **C. Hoffmeister Colonia**

(b) Address **6464 Chippewa St.**

19. (a) **APR 23 1945** (b) **E. G. Gaudron**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **011**

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **4139-a Manchester Avenue**
(If rural, give location)

(e) Citizen of foreign country? **-** (Yes or No)

If yes, name country **-**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **20th,**
year **1945** hour **4:12** minute **A.** M.

21. I hereby certify that I attended the deceased from **August 31, 1936** to **April 20, 1945**
that I last saw him alive on **April 20, 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **EDEMA, PULMONARY,** **6 hrs.**

Due to **CORONARY ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL DAMAGE AND INSUFFICIENCY.** **93d** **Unknown**

Other conditions **Arthritis, deformans.** **Unknown**

PHYSICIAN

Major findings: **No surgery.**

Of operations **No autopsy.**

Of autopsy **No autopsy.**

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) **NO**

(b) Date of occurrence

(c) Where did injury occur? **NO**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

Mortuary **While at work** **at home** **at work**
(Specify type of place) (e) Means of injury

23. Signature **E. V. EDWARDS, MAJOR, M.C.A.** (M. D. or other)

Address **CLINICAL DIRECTOR.** Date signed **4/20/45**

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

16000

JUN 1 9 1945

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... *Louis C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address... *7814 S. Broadway*

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.