

FILED AUG 3 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 818

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH

(a) County St. Louis Mo.
(b) City or town St. Louis Mo.
(c) Name of hospital or institution Homan Chalmers Hosp - 2
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED

(a) State Mo. (b) County St. Louis
(c) City or town St. Louis Mo. 1
(d) Street No. 5800 ARSENAULT
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

HARRY BURKE

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Black 5. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive APT. 1889
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years APT - 56 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace: Wichita (City, town, or county) KS (State or foreign country)

10. Usual occupation Wichita

11. Industry or business Wichita

12. Name ANDREW BURKE

13. Birthplace Wichita (City, town, or county) KS (State or foreign country)

14. Maiden name Wichita

15. Birthplace Wichita (City, town, or county) KS (State or foreign country)

16. (a) Informant Wichita

(b) Address Wichita

17. (a) Bureau (b) Date thereof 7-10-40 (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical

18. (a) Signature of funeral director Wichita

(b) Address Wichita

19. (a) JUL 30 1945 (Date received local registrar) J. J. Buchack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE, day 12, year 1945, hour _____ minute 25 am

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: LOBAR PNEUMONIA
Due to _____
Due to _____

Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: 108
Of operations _____
Of autopsy _____

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) _____ of injury _____

23. Signature Wichita (M. D. or other) _____
Address _____ Date signed 7/9/45

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

MOTHER, FATHER

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.....

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.