

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U.S. GOVERNMENT PRINTING OFFICE: 1945
STANDARD CERTIFICATE OF DEATH
1003

State File No. 28892
Registrar's No. 8316

Registration District No. 318
Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County
(b) City or town **ST. Louis, MO**
(c) Name of hospital or institution: **City Isolation Hospital**
(d) Length of stay: In hospital or institution. **9-6-45 to 9-24-45**
In this community, years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **060**
(c) City or town **ST. Louis, MO.** (if outside city or town limits, write "RURAL") **17**
(d) Street No. **5800 Arsenal ST.** (if rural, give location) **13 9**
(e) Citizen of foreign country? (Yes or No) **0**
If yes, name country.

3. (a) PRINT FULL NAME **Anna Burk**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **None**

4. **Female** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced **2**
6. (b) Name of husband or wife **Thomas E. Burk**
6. (c) Age of husband or wife if alive, years
7. Birth date of deceased **May 20 1890**
(Month) (Day) (Year)

8. AGE: Years **55** Months ~~11~~ Days ~~11~~
If less than one day, hr. min.

9. Birthplace **Ireland** (City, town, or county) (State or foreign country) **4**
10. Usual occupation **Nil**

11. Industry or business
12. Name **Daniel Byrne**
13. Birthplace **Ireland** (City, town, or county) (State or foreign country) **4**
14. Maiden name **Elizabeth Mulligan**
15. Birthplace **Ireland** (City, town, or county) (State or foreign country) **11**

16. (a) Informant **City Infirmary Records**
(b) Address **Burial**
17. (a) **Burial** (b) Date thereof **9-26-45**
(c) Place of burial or cremation **Calvary Cemetery**
(Month) (Day) (Year)

18. (a) Signature of funeral director **Cullinane Bros.**
(b) Address **3320 N. Kingshighway**
19. (a) **SEP 25 1945** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **24** year **1945** hour **7** minute **30 A** M.
21. I hereby certify that I attended the deceased from **9-6** to **Sept 24 1945**
that I last saw **her** alive on **Sept 24 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis** Duration **1 Yr.**
Due to **Osteo Arthritis** Unknown
Due to **93d**

Other conditions (Include pregnancy within 3 months of death)
Major findings: 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) (a) Means of injury
23. Signature **Robert Bredbeck** (M. D. or other)
Address **5800 Arsenal St** Date signed **9-24-45**

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.....

working under my personal supervision.

Registered Apprentice No.

Signed.....

Fred Truck

Licensed Embalmer No. 3186

P. O. Address: St. Louis, Mo.

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..

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. oct
Registrar's No. 8316

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Anna Burk
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September
year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I first saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 20
(Month) (Day) (Year)

Duration _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years 55 Months _____ Days _____ if less than one day _____ min.

Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) OCT 15 1945 (b) J. F. Bredesch
(Date received local health officer) (Registrar's signature)

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-28892