

S. No. 2
M-5-43
v. 5-17-39
I. X36671

FILED SEP 31 1945

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
Homer G Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **23 days** (Specify whether
in this community **43 yrs** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis 000**

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

(d) Street No. **2317 Walnut**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Horace Burks**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **487-118-5178**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **12**
year **1945** hour **7** minute **15** P.M.

4. Sex **Male 2** **5. Color or race** **Col.**

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

6. (b) Name of husband or wife **Loretta Burks**

6. (c) Age of husband or wife if alive **50** years

7. Birth date of deceased **October 29 1881**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
August 20, 1945 to September 12, 1945;
that I last saw him alive on **September 12, 1945;**
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
63	10	14	hr. _____ min.

Immediate cause of death
Duodenal Ulcer with Poss Carcinoma of Stomach

Due to _____

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

Due to _____

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

10. Usual occupation **Barber**

11. Industry or business _____

12. Name **Harrison N. Burks**

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

14. Maiden name **PareLee Lovin**

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

16. (a) Informant **Loretta Burks**
(b) Address **2317a Walnut Avenue**

17. (a) Burial (b) Date thereof **9 17 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters Cemetery**

18. (a) Signature of funeral director **W. M. Green**
(b) Address **3517 Laclède Ave.**

19. (a) SEP 15 1945 (b) _____
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Major findings:
Of operations _____
Of 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) _____

(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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature **B. J. Murphy** (M. D. or other) _____
Address **2601 N. Whittier St.** **Date signed** **9/13/45**

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

Melvin Edward Green

Registered Apprentice No. 383

working under my personal supervision.

Signed

M. E. Green

Licensed Embalmer No. 1173

P. O. Address 3517 Laeblade Ave

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.