

No. 2
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 5-17-39
 X37823

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED JAN 25 1948 **STANDARD CERTIFICATE OF DEATH**

143

State File No.

1003

Registrar's No.

541

Registration District No.

318

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
 (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. Anthony's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

3. (a) PRINT FULL NAME EDWARD J. BURKE

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Irene L. Burke 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased January 28th 1885
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	11	18	hr. min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

12. Name Michael Burke
 13. Birthplace Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Augustine Nolde
 15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Irene L. Burke - Wife,

(b) Address 4215 Botanical Avenue,

17. (a) burial (b) Date thereof 1-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Int. Calvary Cemetery

18. (a) Signature of funeral director Sullivan Undertakers,

(b) Address 2849 North Euclid Avenue,

19. (a) JAN 17 1948 J. F. Presick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 4215 Botanical Avenue,
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 16th
 year 1946 hour 6:45 minute A. M.

21. I hereby certify that I attended the deceased from 1/12, 1944 to 1-15, 1946

that I last saw him alive on 1-15, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis,

Due to 92

Other conditions Hypertension
(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?.....

(Specify type of place) While at work?..... (Specify type of injury).....

23. Signature Sped. L. Terra (M.D. or other) 1/16/46
 Address 4065 S. Grand Date signed 1/16/46

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

2353

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 17
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Dr. J. L. Ferris
4065 So. Grand
LO. 2711

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 Robert L. Brinkman

Licensed Embalmer No. 3553

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.