S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAR 27 1946

State File No. 10970

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 2557

1. PLACE OF DEATH:
(a) County: ~~St. Louis County~~ St. Louis Mo.
(b) City or town: (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4637 San Francisco Ave /
(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)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County:
(c) City or town: St. Louis. Mo. (If outside city or town limits, write "RURAL")
(d) Street No.: 4637 San Francisco Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: DODDRIDGE BURKS
3. (b) If veteran, name war:
3. (c) Social Security No. None
4. Sex: Male
5. Color or race: White
6. (a) Single, ~~widowed~~, ~~married~~, ~~divorced~~ Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Jan. 28-1871 (Month) (Day) (Year)
8. AGE: Years 75 | Months 1 | Days ~~25~~ | If less than one day hr. min.
9. Birthplace: Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: Nil
11. Industry or business:
FATHER 12. Name: Samial O Burks
13. Birthplace: Missouri (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Elizza Mc Comb
15. Birthplace: Missouri (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Minnie Enderson
(b) Address: 4537 San Francisco Ave
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-18-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Henley Missouri
18. (a) Signature of funeral director: Henry L Werdmuller
(b) Address: 6203 Gravois Ave
19. (a) MAR 18 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 15 year 1946 hour 10 minute a.m.
21. I hereby certify that I attended the deceased from 3-14-46, 19..., to 3-15-46, 1946 that I last saw him alive on 3-15-46, 19..., and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	
Due to: Hypertention	
Due to: Auricular Fibrillation	
Due to:	
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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: E. A. Lanscher (M. D. or other) M.D.
Address: 4885 Natural Bridge Date signed: 3/15/46

(Licensed Embalmer's Statement on Reverse Side)

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 John Cygorowski

Licensed Embalmer No. 3398

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.