

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:
2315 S. 12th Street /
(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 Missouri (b) County 000

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

(d) Street No. 2315 S. 12th Street
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Michael A. Burke

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

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 4, 1861
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28
year 1947 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb 29, 1947, to Apr 25, 1947, that I last saw him alive on Apr 25, 1947, and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>85</u>	<u>9</u>	<u>24</u>	hr. _____ min. _____

Immediate cause of death Cerebral hemorrhage Duration 10 hrs.

Due to Essential hypertension 5 yrs.

Due to _____

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

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

10. Usual occupation Retired

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____
Of autopsy _____

11. Industry or business _____

12. Name Thomas Burke

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

14. Maiden name Don't Know

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

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? _____

16. (a) Informant Ruth Burke

(b) Address 911 Allen Ave.

17. (a) Burial (b) Date thereof 5-1-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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

23. Signature J. F. Bredeck (M. D. or other) MD
Address 2026 25th St Date signed 4/27/47

18. (a) Signature of funeral director Weick Bro. Und. Co.

(b) Address 2201 S. Grand Bl.

19. (a) APR 29 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

APR 29 1947

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

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.....

.....**James R. Dunn**....., Registered Apprentice No. **403**
working under my personal supervision.

Signed.....*Ray A. Stewart*.....
Licensed Embalmer No. **3722**

P. O. Address **2201 S. Grand Bl.**

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.