

No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 23 1947
Registration District No. 3

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15837
Registrar's No. 851

Primary Registration District No. 3063

1. PLACE OF DEATH:
(a) County ST. LOUIS COUNTY
(b) City or town CLAYTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. LOUIS COUNTY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 DAYS 4 HRS 30 MIN
(Specify whether
In this community 2 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ST. LOUIS CO.
(c) City or town NORMAN
(If outside city or town limits, write "RURAL")
(d) Street No. 7626 NATURAL BRIDGE
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

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

4. Sex FEMALE 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 (Day) (Year)

7. Birth date of deceased DEC 9 1860
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
86 4 9 hr. min.

9. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
12. Name THOMAS E. BURKE
13. Birthplace IRELAND
(City, town, or county) (State or foreign country)
14. Maiden name KATHRYN BURKE
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. C.E. Graves
(b) Address 676 Salem St., Rolla, Mo.

17. (a) Burial (b) Date thereof 4-14-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Chapel

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindall Blvd.

19. (a) 4-13-47 (b) Carole G. Skyles
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12
year 1947 hour 2 minute 15 P. M.
21. I hereby certify that I attended the deceased from April 9
1947 to April 12, 1947
that I last saw h. ER alive on April 12, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolus
Duration _____
Due to 838
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? U

(Specify type of place) _____
(e) Means of injury _____
While at work? _____
23. Signature [Signature] (M. D. _____)
Address 605 BRENTWOOD BLVD Date signed 4-12-47

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Kridell

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.