

FILED JAN 16 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2342

318

1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <i>St. Louis Mo</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Mo</i> COUNTY <i>Mo</i>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>City</i>		c. LENGTH OF STAY (In this place) <i>11/49/12/50</i>		c. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN <i>Missouri</i>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>City Infirmary</i>				d. STREET ADDRESS (If rural, give location) <i>10 - 4142 Margareta</i>				
3. NAME OF DECEASED (Type or Print) a. (First) <i>Alice</i> b. (Middle) <i>M.</i> c. (Last) <i>Burke</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>1 - 2 - 1950</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>		8. DATE OF BIRTH <i>4-15-1876</i>		
9. AGE (In years, Months, Days) <i>72</i>		10. IF UNDER 1 YEAR		11. IF UNDER 1 HR.		12. IF UNDER 1 MIN.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Ireland 4</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13a. FATHER'S NAME <i>James M. Namara</i>		13b. MOTHER'S MAIDEN NAME <i>Wm. Hale</i>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME <i>Derald Burke</i> ADDRESS <i>4142 Margareta</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral Thrombosis (Recurrent)</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>				
				ANTECEDENT CAUSES DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) <i>Left Hemiplegia (5 yrs)</i>				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>97</i>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>332X</i>				
22. I hereby certify that I attended the deceased from <i>Nov 1, 1949</i> , to <i>Jan 2, 1950</i> , that I last saw the deceased alive on <i>Jan 2, 1950</i> , and that death occurred at <i>11:39 a.m.</i> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <i>Masao Ohnishi M.D.</i>				23b. ADDRESS <i>5800 Arsenal</i>		23c. DATE SIGNED <i>1-2-50</i>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>1-5-50</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>		24d. LOCATION (City, town, or county) (State) <i>St. Louis Mo</i>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <i>J. B. Lasater</i>		GENERAL DIRECTOR'S SIGNATURE <i>Dullman</i> ADDRESS <i>Funeral Directors</i>						

(Licensed Embalmer's Statement on Reverse Side)

2849 N. Euclid

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

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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed *Gustav W Dietele* \_\_\_\_\_

Licensed Embalmer No. *4329* \_\_\_\_\_

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.