

FILED MAY 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15161

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 3063		Registrar's No. 1119	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY St. Louis		b. CITY (If outside corporate limits, write RURAL and give township) Clayton		a. STATE Missouri		b. COUNTY St. Louis	
c. LENGTH OF STAY (in this place) P.O.A.		c. CITY (If outside corporate limits, write RURAL and give township) 87 TOWN Lemay		d. STREET ADDRESS I22 E. Felton		4870 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital D.O.				A.			
3. NAME OF DECEASED (Type or Print) HERMAN		a. (First)		b. (Middle) *****		c. (Last) BURKE	
4. DATE OF DEATH April 29, 1950		(Month) (Day) (Year)		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan. 10, 1880		9. AGE (In years less birthday) 70		IF UNDER 1 YEAR Months Days	
IF UNDER 1 HR. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Herman Burke		13b. MOTHER'S MAIDEN NAME Gertrude Osterkamp		14. NAME OF HUSBAND OR WIFE Margaret	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wm. A. Steinhoff 2230 S. 3rd, St. Louis, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cause unknown		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				none	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) _____				DUE TO (c) _____	
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)		7955	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Local Registrar of Vital Statistics				23b. ADDRESS 651 South Brentwood Boulevard		23c. DATE SIGNED 5/1/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 2, 1950		24c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul		24d. LOCATION (City, town, or county) (State) 7030 Gravois St. Louis Mo.	
DATE REC'D BY LOCAL REG. 5-1-50		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS U. & L. Co. 781 1/2 S. Broadway St. Louis, Mo.			

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

*Harry J. Schenker*

..... Licensed Embalmer No. *2679* .....

P. O. Address *7814 Broadway* .....

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.