

FILED MAR 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5927
1634
Registrar's No.

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. 1003		Registrar's No.				
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				
d. FULL NAME OF HOSPITAL OR INSTITUTION 5936 EIZEL				d. STREET ADDRESS (If rural, give location) 5936 EIZEL				2059		
3. NAME OF DECEASED (Type or Print) a. (First) Michael			b. (Middle) F		c. (Last) BURKE		4. DATE OF DEATH (Month) (Day) (Year) FEB 17 1951			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH Sept 25 1870		9. AGE (In years last birthday) 80		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk				10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) St. Louis		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME THOMAS BURKE			13b. MOTHER'S MAIDEN NAME BRIDGET Mc ENCARV			14. NAME OF HUSBAND OR WIFE ANNE E DUGAN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Anne Burke				ADDRESS 5936 EIZEL	
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) Cardio-vascular disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 5 years		
19a. DATE OF OPERATION No		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)						
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 H221						
22. I hereby certify that I attended the deceased from Jan 1947, to Feb 17, 1951, that I last saw the deceased alive on Feb 16, 1951, and that death occurred at 7:30 a.m., from the causes and on the date stated above.										
23a. SIGNATURE Dr. J. J. Langan Jr. M.D.				23b. ADDRESS 5803 Plymouth St. Louis		23c. DATE SIGNED Feb 17 1951				
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb 20 1951		24c. NAME OF CEMETERY OR CREMATORY CALVARY		24d. LOCATION (City, town, or county) (State) St. Louis MO				
DATE REC'D BY LOCAL REG. FEB 19 1951		REGISTRAR'S SIGNATURE J. B. Hunter			25. FUNERAL DIRECTOR'S SIGNATURE Cullen Kelly 4386 Linden					

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

with

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 *James G. Lammers*

Licensed Embalmer No. *4142*

P. O. Address *St Louis*

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.