

FILED OCT 23 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34889

Registrar's No. 8693

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2149	
c. LENGTH OF STAY (In this place)		d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BARNES HOSPITAL	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) 6404 - Chippen	

3. NAME OF DECEASED (Type or Print) a. (First) RALPH	b. (Middle) JOHN	c. (Last) BURKE	4. DATE OF DEATH (Month) (Day) (Year) 10 2 51
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 4-6-1891
9. AGE (In years last birthday) 60	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Operay	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME John Burke	13b. MOTHER'S MAIDEN NAME Katherine Bredak	14. NAME OF HUSBAND OR WIFE Worthy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Worthy Burke
		ADDRESS 6404 - Chippen

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERNAL BETWEEN ONSET AND DEATH 27 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ARTERIOSCLEROTIC HEART 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. CONGESTIVE HEART FAILURE			2 weeks
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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? 4200

22. I hereby certify that I attended the deceased from 9/25, 1951, to 10/2, 1951, that I last saw the deceased alive on 10/1, 1951, and that death occurred at 10:30P.m., from the causes and on the date stated above.

23a. SIGNATURE FR Bradley	(Degree or title) M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 10/2/51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Oct-4-1951	24c. NAME OF CEMETERY OR CREMATORY Resurrection	24d. LOCATION (City, town, or county) (State) St Louis - Mo

DATE REC'D BY LOCAL REG. OCT 2 1951	REGISTRAR'S SIGNATURE J. Earl Smith - W.C.	25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home	ADDRESS 6322 S. Grand Blvd.
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WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision. *W*

Student
Student Embalmer

Signed *David Van Fossen*

Licensed Embalmer No. *4282*

P. O. Address *6322 La Grand*

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.