

FILED MAY 1 - 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14104**
Registrar's No. **3619**

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

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place) 2 DAYS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION PARK LANE		d. STREET ADDRESS (If rural, give location) IV 4635 E. WRIGHT 0	

3. NAME OF DECEASED (Type or Print) a. (First) BLANCA b. (Middle) V c. (Last) BURKE			4. DATE OF DEATH (Month) (Day) (Year) APRIL 16 1952
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5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH NOV 3 1887	9. AGE (In years last birthday) 64	10. MONTHS 1	11. DAYS 14	12. HOURS 0	13. MIN. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST LOUIS Mo. 1	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME JOHN BURKE	13b. MOTHER'S MAIDEN NAME MARGARET BURKE	14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Joseph T. Burke	ADDRESS 4635 E. Wright
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Cardiac Val. Disease		INTERVAL BETWEEN ONSET AND DEATH 7 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Interstitial Nephritis		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? 592X
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22. I hereby certify that I attended the deceased from **Aug 15**, 19**51**, to **April 16**, 19**52**, that I last saw the deceased alive on **April 16**, 19**52** and that death occurred at **10 PM.**, from the causes and on the date stated above.

23a. SIGNATURE Raymond L. Heid M.D.	(Degree or title)	23b. ADDRESS 2739 N Grand	23c. DATE SIGNED 4-16-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-19-52	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST. LOUIS - MO
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 17 1952	25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith MO	ADDRESS Culture-Kelly 4386 Lindell
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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 *James G. Lammere*.....

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.