

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36226**
Registrar's No. **9554**

NOV 12 1952

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 MISSOURI 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, 2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4320 SANFRANCISCO		d. STREET ADDRESS (If rural, give location) 4320 SANFRANCISCO AVE	
3. NAME OF DECEASED (Type or Print) a. (First) FRANCIS b. (Middle) X, c. (Last) BURKE		4. DATE OF DEATH (Month) (Day) (Year) OCT, 15, 1952	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, MARRIED (Specify)	8. DATE OF BIRTH 10/30/1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 74 IF UNDER 1 YEAR: Months Days IF UNDER 6 Mths: Hours Mts.
11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME ANTHONY GALLAGHER		13b. MOTHER'S MAIDEN NAME JANE MCGHOARTY	
14. NAME OF HUSBAND OR WIFE NEAL BURKE		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. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS NEAL BURKE 4320 SANFRANCISCO AVE	
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) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Cerebral artery sclerosis 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.	
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)	
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 334X	
22. I hereby certify that I attended the deceased from Oct 15, 1952 to Oct 15, 1952 , that I last saw the deceased alive on Oct 15, 1952 , and that death occurred at 5:15 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Francis Burke MD (Degree or title)		23b. ADDRESS 4714 W. Harrison St.	
23c. DATE SIGNED 10/15/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 10/18/52	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI
DATE REC'D BY LOCAL REG. OCT 16 1952	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE AVE	

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 Albert Mayfield

Licensed Embalmer No. 103077

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.