

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31670**
Registrar's No. **7700**

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.		c. CITY OR TOWN St. Louis.	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 1 day		e. STREET ADDRESS (If rural, give location) 25 Missouri Athletic Club. 2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital.			

3. NAME OF DECEASED (Type or Print) a. (First) EDWARD b. (Middle) J. c. (Last) BURKLEY.			4. DATE OF DEATH (Month) (Day) (Year) Aug 19, 1954.		
5. SEX Male.	6. COLOR OR RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed.	8. DATE OF BIRTH June 5, 1884.		9. AGE (In years last birthday) 70. If UNDER 1 YEAR Months Days If UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired.. Insurance Manager.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Cleveland, Ohio.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE Harriett Burkley.	
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. yes		17. INFORMANT'S SIGNATURE OR NAME ADDRESS David L. Burkley, #116 Clara, Webster.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic carcinoma of lung with general metastases 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 Hypertensive - arteriosclerosis Cardio-vas. dis. Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 3 years 15 years	
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19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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? 162x	

22. I hereby certify that I attended the deceased from June, 1942, to Aug 19, 1954, that I last saw the deceased alive on Aug 19, 1954, and that death occurred at 6 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John J. Hammond M.D.		23b. ADDRESS 634 N. Grand		23c. DATE SIGNED 8/19/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Ent. Burial.		24b. DATE 8/21/54.		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum.	
24d. LOCATION (City, town, or county) (State) #7800 St Charles Rock Road.					

DATE REC'D BY LOCAL REG. AUG 19 1954		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons, #7233 Delmar Blv'd.,	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr John Hammond.
Mo. Theatre Bld'g.
2:30-5 P.M.

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.....
Signature of Student Embalmer

Signed.....
Arnold W. Schoene

Licensed Embalmer No. *386*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.