

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003849  
STATE FILE NUMBER

FILED FEB 4 1959 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> 2159 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Length of stay in lb <b>3 mo.</b>	d. STREET ADDRESS (If outside, give location) <b>5218 So. Kingshighway</b> Blv. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>D.</b> Last <b>Burkett</b>	4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1959</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1916</b>	9. AGE (In years last birthday) <b>42</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Branch Manager</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Amer Optical Co.</b>	11. BIRTHPLACE (City and state or country) <b>Portage, Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Gary Burkett</b>	13b. MOTHER'S MAIDEN NAME <b>Bessie Diehl</b>	14. NAME OF HUSBAND OR WIFE <b>Rose Burkett</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes</b> <b>WW II</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Rose Burkett, 5218 So. Kingshighway</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Over 1 year</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Brain Tumor</b>	
	DUE TO (c) <b>(Meningioma - Frontal lobe)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cardiac arrest followed anesthetic given for angiogram study!</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>223xv</b>
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20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Johnstown, Pa.</b>	COUNTY	STATE
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21. I attended the deceased from <b>12-15-58</b> to <b>Jan 4, 1959</b> and last saw her alive on <b>Jan 3, 1959</b> Death occurred at <b>12:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Emil P. Helber M.D.</b>	22b. ADDRESS <b>634 N. Grand Ave</b>	22c. DATE SIGNED <b>1-5-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>1-5-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOCAL</b>	23d. LOCATION (City, town, or county) (State) <b>Johnstown, Pa.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>1-5-59</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donko M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MS SEP 1 3 1958

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 *Robert M. Murray* .....

Licensed Embalmer No. *3749* .....  
P. O. Address *J. Davis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.