

FURI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041631

FILED VS DEC 11 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210853**

INDEXED

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, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. ANTHONY HOSP.		d. STREET ADDRESS (If outside, give location) 3170 CALIFORNIA	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH W BURKE SR			4. DATE OF DEATH Month Day Year NOV 21 1959		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH APR. 6 1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DAY LABORER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY U - S - A
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13a. FATHER'S NAME WILLIAM BURKE	13b. MOTHER'S MAIDEN NAME ANNA SINCLAIR	14. NAME OF HUSBAND OR WIFE JOSEPHINE BURKE
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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. 492-09-7475	17. INFORMANT Address JOSEPHINE BURKE 3170 CALIFORNIA
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis		Relay.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic Imparcarditis	4 mo.
	DUE TO (c) Quiricullar fibrillation	3 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Congestive Cardiac 420.1	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> None <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. Month, Day, Year None	20d. INJURY OCCURRED WHILE AT WORK <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.) None	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from October 7-1959 to Nov. 21-59 and last saw her/him alive on Nov. 21-1959 Death occurred at 11:30 P.m. 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) Wm. J. Sinclair M.D.	22b. ADDRESS 2707 Durand Ave. St. Louis 18 MO	22c. DATE SIGNED 11-24-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE NOV 25 1959	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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24. FUNERAL DIRECTOR ADDRESS Thomas Kuttis 2906 Gravois	25. DATE RECD. BY LOCAL REG. NOV 24 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Samuel C. Hill

Licensed Embalmer No. 43477

P. O. Address 2906 Du

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.