

FILED VS MAR 1 1961 318

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

AFFIDAVIT OF

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, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 1213 Walton		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Burke			4. DATE OF DEATH Month Day Year 2 10 61
5. SEX Fem.	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-10-61
9. AGE (last birthday)		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min. 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Saint Louis, Missouri
12. CITIZEN OF WHAT COUNTRY USA.		13a. FATHER'S NAME	
13b. MOTHER'S MAIDEN NAME Shirley Burke		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address 2601 N. Whittier	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature birth			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)			776x
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 2-10-61 to 2-10-61 and last saw her her alive on 2-10-61 Death occurred at 9:45 p. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Type or print)		22b. ADDRESS 2601 N. Whittier	
22c. DATE SIGNED 2-15-61			
23a. BURIAL, CREMATION, REMOVAL (Specify) FEB 28 1961		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)	
24. FUNERAL DIRECTOR Rowland Mortuary Svc.		25. DATE RECD. BY LOCAL REG. FEB 23 1961	
ADDRESS 4104-06 Manchester		26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M.D.	

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. x

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.