

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **10860**

FILED DEC 1 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		Length of stay in 1b		c. CITY OR TOWN St Louis	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St Anthony, s Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 3231 Itaska Street	

3. NAME OF DECEASED (Type or print) First Middle Last John William Burke			4. DATE OF DEATH Month Day Year Nov 21 1961		
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 8/27/1900	9. AGE (last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer		10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (City and state or country) St Louis Mo	
12. CITIZEN OF WHAT COUNTRY U S		13a. FATHER'S NAME John Burke		13b. MOTHER'S MAIDEN NAME Elizabeth Mc Inteer	
14. NAME OF HUSBAND OR WIFE Ethel		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 Ethel Burke		Address 3231 Itaska Street			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 18 min
DUE TO (b) Coronary Artery Disease		
DUE TO (c) 4201		
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 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.)
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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
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21. I attended the deceased from **June 1960** **Nov. 21-61** and last saw him alive on **11-20-61**
 Death occurred at **5 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Charles A. Nester M.D.	22b. ADDRESS 5600 S Compton	22c. DATE SIGNED 11-21-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/24/61	23c. NAME OF CEMETERY OR CREMATORY S S Peter & Paul Cem	23d. LOCATION (City, town, or county) St Louis Missouri
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24. FUNERAL DIRECTOR Moydell Funeral Home	ADDRESS 1926 Allen	25. DATE RECD. BY LOCAL REG. NOV 22 1961	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 Harley P. Jaelle Jr

Licensed Embalmer No. 4950

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.