

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **4511** **Enright**)..... St. Ward

File No. **35251**
 Registered No. **10430**
 St. Ward

2. FULL NAME

(a) Residence, No. **4511** **Enright** St. **12** Ward.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Margaret**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jun 26 1859**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 68 4 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Rail Road Clerk**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer **Tennel R R**

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Ireland**

10. NAME OF FATHER **J C Burke**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

12. MAIDEN NAME OF MOTHER **Jane McMarra**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

14. INFORMANT **Margaret Burke**
 (Address) **4511 Enright**

15. FILED **21 1927** **Man G Starceoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov 21 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Nov 19 1927** to **Nov 21 1927**, that I last saw him alive on **Nov 20 1927**, and that death occurred, on the date stated above, at **6 A** m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Broncho Pneumonia
10711
 (duration) yrs. mos. ds. **3**

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED (DIAGNOSIS)

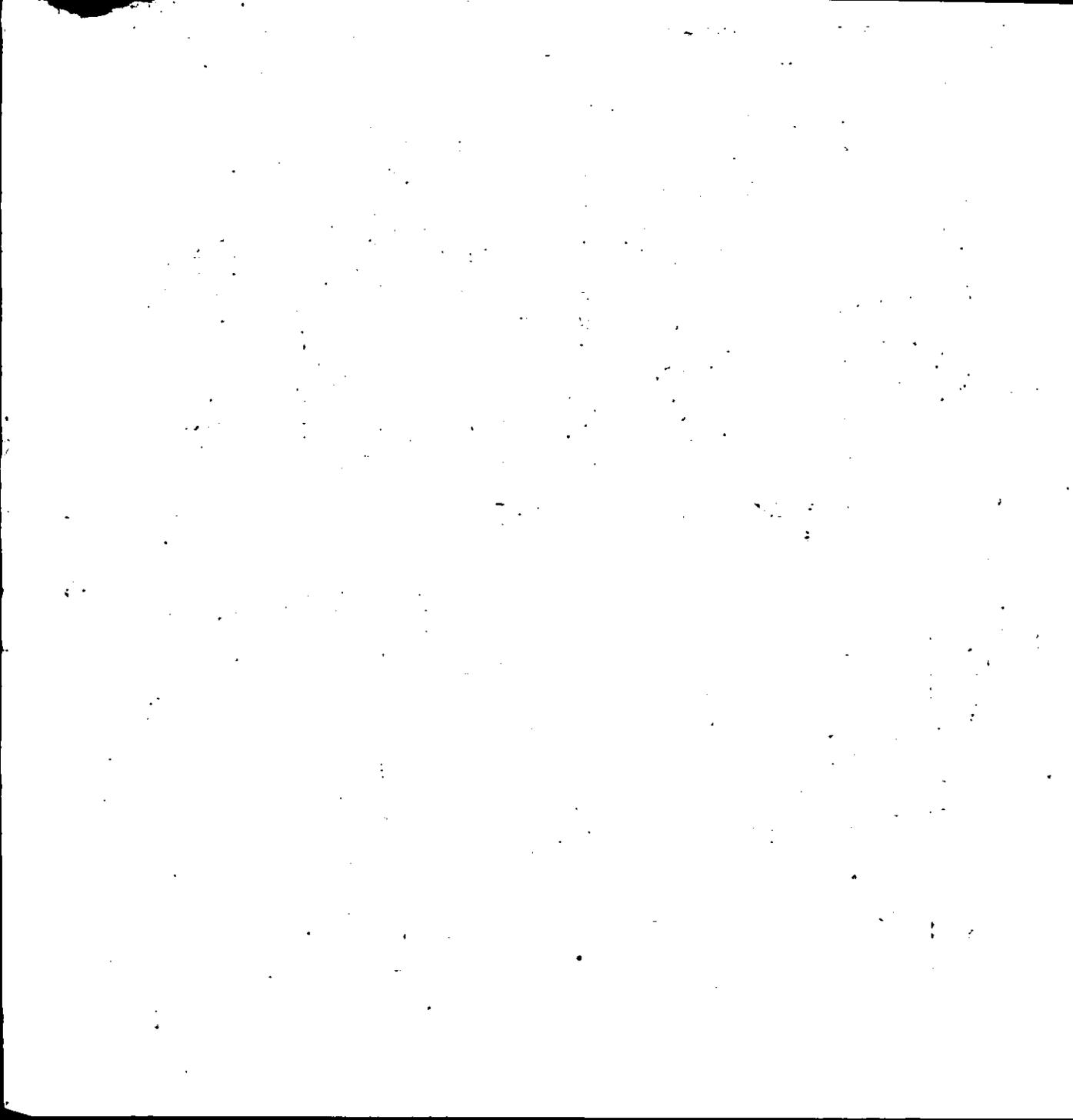
(Signed) **Dr. W. F. Henderson** M. D.

Nov 21, 1927 (Address) **Tramchester Bank Bldg.**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Calvary** DATE OF BURIAL **Nov 23 1927**

20. UNDERTAKER **Louella Kelly** ADDRESS **4526 Easton**



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....
 Township..... Primary Registration District No. 1003 Registered No. 10430
 City St. Louis (No.....) St. Ward.....

2. FULL NAME

John Buske
 (a) Residence No..... St. Ward.....
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

5a. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....
 (STATE OR COUNTRY).....

10. NAME OF FATHER Samuel C. Buske

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
 (STATE OR COUNTRY).....

12. MAIDEN NAME OF MOTHER Johns MacNamara

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
 (STATE OR COUNTRY).....

14. INFORMANT.....
 (Address).....

15. FILED 16 19 Mar 6 Starckoff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 21 1927

17. I HEREBY CERTIFY, That I attended deceased from..... to....., 19.....
 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration)..... yrs. mos. ds.
 CONTRIBUTORY.....
(SECONDARY)..... (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... DATE OF BURIAL.....

20. UNDERTAKER..... ADDRESS.....

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY L.

SUPPLEMENTARY

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. 10430
 City..... St. Ward)

2. FULL NAME

John M. Burke

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov. 21 19 27*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

17. I HEREBY CERTIFY That I attended deceased from 19.....
 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

10. NAME OF FATHER *Samuel M. Burke*

DID AN OPERATION PRECEDE DEATH?..... DATE OF..... WAS THERE AN AUTOPSY?.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

WHAT TEST CONFIRMED DIAGNOSIS?..... (Signed)....., M. D.

12. MAIDEN NAME OF MOTHER *Jane Macchamara*

19. (Address)

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT *(Miss) Marie E. Burk*
 (Address) *4511 Emiglan*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED *DEC 17 1927*
Marie Starkloff
 REGISTRAR

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

TEMPORARILY SUPPLEMENTARY

15053-5