

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

Do not use this space.

22105

1. PLACE OF DEATH

County.....

Registration District No. **791**
1003

File No.

Township.....

Primary Registration District No.

Registered No. **6279**

City **St. Louis Mo.** (No. **1**)

Carondelet City Hosp. #1

Ward)

2. FULL NAME

James E. Burke

(a) Residence No. **419 Wash** St., **25** 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

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

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

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

Sept 29 - 1884

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

43

8

12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

machinist

(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)

St. Louis Missouri

10. NAME OF FATHER

James Burke

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

Ireland

12. MAIDEN NAME OF MOTHER

Kate Lavin

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

Ireland

14.

INFORMANT (Address)

Mrs. Kate Burke 3426 Eads Av.

15.

FILED

12 1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

June 11 1928

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19....., and that I last saw him..... alive on, 19....., and that death occurred, on the date stated above, at **4352 A.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

CONTRIBUTORY (SECONDARY)

90 B (duration) yrs. **93** mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **J. W. Kerner, M.D.**

6/12 1928 (Address) **Dep. Coroner**

*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

DATE OF BURIAL

Calvary Cemetery June 13 1928

20. UNDERTAKER

ADDRESS

E. J. Schmur 3125 Lafayette

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

