

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

Do not use this space.

38894

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
City **St. Louis**

File No. **11347**
Registered No. **11347**
St. Ward)

2. FULL NAME

(a) Residence, No. **6604 Hartford St.** **3** Ward.

(Usual place of abode) 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** Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
abt. 70 X X

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Police Officer
(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) Ireland

10. NAME OF FATHER Patrick Burke

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mary Burke
(Address) 6604 Hartford St

15. FILED NOV 20 1928
19. May E. Kameny REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 18, 1929

17. NO Physician in attendance
I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on 19....., and that death occurred, on the date stated above, at 4:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

RVA
Cerebral Apoplexy
(Non-traumatic)

CONTRIBUTORY (SECONDARY) 740
(duration) yrs. 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.

1120, 1929 (Address) Sep. Corner
*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 Cemetery
DATE OF BURIAL Nov 22, 1929

20. UNDERTAKER Chas. L. Guaghty
ADDRESS 4259 Lindell

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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