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.

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

Do not use this space.

14105

1. PLACE OF DEATH

County ..... Registration District No. 7301

Township ..... Primary Registration District No. ..... File No. .....

City ST. Louis (No. 500 S. Kingshighway St. Louis Childrens Hosp. St. ..... Ward) Registered No. 3436

2. FULL NAME Mary Elizabeth Burke

(a) Residence, No. 1115 Paul St., 22 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: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Child.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 8-12-31

7. AGE: YEARS | MONTHS: 7 | DAYS: 25 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Child
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): ST. Louis, Mo. 1

FATHER
13. NAME: James Burke
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): ST. Louis, Mo.

MOTHER
15. MAIDEN NAME: Louise Morgan
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Arkansas 2

17. INFORMANT (ADDRESS): J. McIlvin, 416 S. Kingshighway

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Calvary DATE: April 9th, 1932

19. UNDERTAKER (ADDRESS): Aug Brockland L&U Co, 1421 N. 9th.

20. FILED: APR -7 1932, 19 Max C Starkey, Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 4-7-32, 19

22. I HEREBY CERTIFY, That I attended deceased from 1-23-32, 19..., to 4-7-32, 19...

I last saw her alive on 4-7-32, 19... Death is said to have occurred on the date stated above, at 5:40 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Meningitis, Cerebral (Non-hemolytic streptococcus)	11/1/31
8 P.B.	
9 A	
Other contributory causes of importance: Hydrocephalus	11/12/31

Name of operation: Craniotomy Date of 2/9/32

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19...
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? —
If so, specify .....

(Signed) J. R. Adams, M. D.
(Address) 500 S. Kingshighway

[illegible]