

**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. **781**
 Township..... Primary Registration District No. **10033**
 City **St. Louis** (No. **St. John's Hospital**) St. Ward)
 (Registered No. **788**)

2. FULL NAME

Mellie A. Burke
 (a) Residence, No. **4201 W. Evans** St. **11** Ward. (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 Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 27 1867		
7. AGE	YEARS 65	MONTHS 3
	DAYS 24	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Householder	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. At Home	
	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.		
FATHER	13. NAME John Burke	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Duland	
MOTHER	15. MAIDEN NAME Honor Morrison	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Duland.	
17. INFORMANT Lenna Burke (ADDRESS) 4201 W. Evans		
18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE Jan 28, 1933		
19. UNDERTAKER William Keefe (ADDRESS) 1416 N. 7th St.		
20. FILED Jan 22 1933 Miss C. Stahly Registrar		

4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 20 1933**

22. I HEREBY CERTIFY, That I attended deceased from **Jan 19th 1933**, to **Jan 20 1933**
 I last saw her alive on **Jan 20 1933** Death is said to have occurred on the date stated above, at **S.P.** m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset

930 Apoplexy cerebral Jan 19-
0510
823 Arteriosclerosis 1930
950

Other contributory causes of importance:
Hypertensive Heart Disease 1930
Chv. Myocardites

Name of operation **None** Date of

What test confirmed diagnosis? **All** Was there an autopsy? **No**

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? **No**
 If so, specify.....
 (Signed) **J. Anthony Brennan**, M. D.
 (Address) **401 Hubert St. Bldg.**

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.

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