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.

REC'D JUN 12 1939

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

17144
Do not use this space.

791

1. PLACE OF DEATH
(a) County ..... 2 Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 4678
or
(c) City St. Louis (d) Street No. 3668 Laclede ave St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 620 WILLIAM E. BURKE
(a) Residence, No. 3668 Laclede ave St. 18
(Usual place of abode, if no street address, write county or city) (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~~ Ida - Burke
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 6. 1892.
7. AGE YEARS 66 MONTHS 7 DAYS 16 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Physician M.D.
9. Industry or business in which work was done, as saw mill, bank, etc.
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) Kentucky

FATHER
13. NAME Thomas W. Burke
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cinn Ohio

MOTHER
15. MAIDEN NAME Martha Taylor
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Mrs. Ida Burke 3668 Laclede ave
18. BURIAL, CREMATION, OR REMOVAL PLACE Centralia Ill DATE May 24 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edw. F. Howard & Son 4212 St. Louis ave
20. FILED MAY 23 1939 J. F. Budick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 22nd 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan 17th, 1938, to May 22nd, 1939
I last saw him alive on May 17th, 1939. Death is said to have occurred on the date stated above, at 6 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardio-Renal	1-17-38
Other contributory causes of importance:	
Myocarditis, chronic	2-15-38

Name of operation — Date of —
What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no 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) Joseph M. Trigg, M. D.
(Address) 818 Metropolitan Building St Louis Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Guy. W. Wilkinson

Licensed Embalmer No. 35-75

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.