

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26820
Registrar's No. 1269

Registration District No. 204

Primary Registration District No. 204

1-1931
WHILE PLAINLY USE UNFADING BLACK INK—MAKE 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.

1. PLACE OF DEATH:

(a) County ST LOUIS
(b) City or town NORMANDY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: IMMACULATE HEART HOM
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 YEARS
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St Louis
(c) City or town NORMANDY
(If outside city or town limits, write "RURAL")
(d) Street No. 7625 N 4th Bg: D Q C
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME MARY E BURKE: 120

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced, WIDOWED
6. (b) Name of husband or wife JOHN B BURKE 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MARCH 15 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 3 28 hr. min.

9. Birthplace ST LOUIS
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WORK

11. Industry or business HOME

MOTHER FATHER { 12. Name MICHAEL KINSELLA

18. Birthplace IRELAND
(City, town, or county) (State or foreign country)

14. Maiden name ANN GANNON

15. Birthplace IRELAND
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. THAMAN

(b) Address 7-15-34

17. (a) BURIAL (b) Date thereof 7-15-34
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Cullen & Kelly

(b) Address 7317 Michigan Blvd

19. (a) JUL 14 1939 (b) DR. M. J. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 13
year 1939 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis Duration 3da

Due to Cancer of Liver 1yr

Due to Chr Cholelithiasis 6yrs

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none 46

Of autopsy none PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work (Specify type of place) (e) Means of injury _____

23. Signature Scott K. ... Date of on-duty _____
Address 370 ... Date signed 7-14-39

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 Clement McNear

Licensed Embalmer No. 3732

P. O. Address St. Louis

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

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