DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9204

Registration District No. 791 — Primary Registration District No. 1003 — Registrar's No. 2687

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 917 S. Boyle (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 917 S. Boyle (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Katie Burke

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Paul

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April 12, 1870 (Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days 9 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Anthol

FATHER 13. Birthplace (City, town, or county) Hungary (State or foreign country)

MOTHER 14. Maiden name Unknown

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

16. (a) Informant's own signature X Thomas Burke

(b) Address X 917 S. Boyle St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/40 (Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter & Paul

18. (a) Signature of funeral director Edith E. Ambruster

(b) Address 4234 Manchester

19. (a) MAR 22 1940 (Date received and registered) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21 year 1940 hour 3.15 A.M. minute M.

21. I hereby certify that I attended the deceased from 1/1/1938, 19, to 1/10/1940, 19; that I last saw he alive on Jan 10, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis Chronic Hypertension

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Robert Dorr (M. D. or other)

Address 3702 Gravois Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE 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.

REV. 6-17-39 — 1 X19211

3838 Kirkwood
3702 Kraemer

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 Florenz Eynck.

Licensed Embalmer No. 1284

P. O. Address So Louis Mo.

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.