

JUN 15 1940  
Registration District No. 791

Primary Registration District No. 1003

State File No. \_\_\_\_\_  
Registrar's No. 4353

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4743 MAFFITT AVE  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County \_\_\_\_\_  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4743 MAFFITT AVE  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 14  
year 1940 hour 3:45 minute P. M.

21. I hereby certify that I attended the deceased from  
June 10 1939 to May 14 1940  
that I last saw her alive on May 13 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Chronic Parenchymatous Nephritis  
Duration - ?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)  
1/2/1

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) Manner of injury \_\_\_\_\_

23. Signature John B. McInerney M. D. or other MD  
Address 4701 St. Louis Date signed 5/15/40

8. (a) PRINT FULL NAME SARAH L. BURKE (20)

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife EUGENE BURKE 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased JAN. 10 1900  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
40 4 4 hr. min.

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

10. Usual occupation HOUSE WORK

11. Industry or business AT HOME

12. Name UNKNOWN SHUCKERT

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

14. Maiden name UNKNOWN LAMB  
15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant Eugene G. Burke

(b) Address 4743 Maffitt ave.

17. (a) BURIAL (b) Date thereof 5/17/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

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

(b) Address 1416 N. Taylor ave.

19. (a) MAY 16 1940 (b) \_\_\_\_\_  
(Date of death) (Place of death)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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**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.....

*Robert McQuay*

Licensed Embalmer No. 3732

P. O. Address *H. Lewis*

**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.**