

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33730

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8427

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days
(Specify whether
In this community
years, months or days)

8. (a) PRINT FULL NAME Louis Burke

3. (b) If veteran, World War 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Laura Burke 6. (c) Age of husband or wife if alive 35 years
7. Birth date of deceased February 3 1895
(Month) (Day) (Year)

8. AGE: Years 45 Months 8 Days 4 If less than one day
hr. min.

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

10. Usual occupation W.P.A.

11. Industry or business Laborer

12. Name Peter Burke

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

14. Maiden name Julia Crilly
(City, town, or county) (State or foreign country)

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

16. (a) Informant Charles Quarters

(b) Address 4637 Kennerly ave.

17. (a) Burial (b) Date thereof Oct. 11, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Choffmeister & Co.

(b) Address 7814 S. Broadway

19. (a) OCT 11 1940 (b) [Signature]
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State St. Louis (b) County _____
Missouri
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. 4637 Kennerly ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 7,
year 1940 hour 7:25 minute _____ P.M.

21. I hereby certify that I attended the deceased from October 2, 1940 to October 7, 1940
that I last saw him alive on October 7, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary hyperthrophy

Due to _____

Due to _____

Other conditions Obesity
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Cardiac hypertrophy
(Yes) _____

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 Th. W. Fitzgerald (M. D. or other) _____

Address 1515 Lafayette Ave. Date signed 10/8/40

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

Linus C. Hoffmann, Lic. # 3871
working under my personal supervision. Registered Apprentice No.

Signed

Edwin T. Leisinger
Licensed Embalmer No. 4049

P. O. Address 6464 Chippewa

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.