

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **22656**Registration District No. **791** Primary Registration District No. **1003** Registrar's No. **6481**

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:
3920A Shenandoan
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 (Specify whether
 In this community **Life**
 years, months or days)

3. (a) PRINT
FULL NAME**Margaret Burke**3. (b) If veteran,
name war **None**3. (c) Social Security
No. **None**

4. Sex **Female** 5. Color or face **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **John**
 6. (c) Age of husband or wife if
 alive **80** years

7. Birth date of deceased **Jan 20th. 1867**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	75	6	10	hr. min.

9. Birthplace **St. Louis** **Mo**
(City, town, or county) (State or foreign country)10. Usual occupation **Housewife**11. Industry or business **At home**12. Name **Martin Houlihan**13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)14. Maiden name **Mary Collins**15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)16. (a) Informant **Mrs Margurste Carbery**(b) Address **3920A Shenandoan**17. (a) **Burial** (b) Date thereof **8/1/42**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Calvary Cemt.**18. (a) Signature of funeral home **Harrigan & Sheehan Und Co**(b) Address **4415 Washington Blvd**19. (a) **JUL 31 1942** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **CCO**
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No **3920A Shenandoan St**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30th.**
year **1942** hour **7:30 AM** minute M.21. I hereby certify that I attended the deceased from **July 13**
1942 to **July 30, 1942**
that I last saw her alive on **July 29**, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death.

Cerebral apoplexyDue to **Arterial sclerosis**Due to **Hypertension**

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 stati-
cally.

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 **E. M. Albers** (M. D. or other) **M.D.**
 Address **3012 Lafayette** Date signed **7-31-42**

844 (Licensed Embalmer's Statement on Reverse Side)

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

Dr. Adriano
3012 Lafayette
P-2138

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.....

Homer W. Dritz

Licensed Embalmer No.....

3882

P. O. Address.....

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, fact should be so stated above.