

STANDARD CERTIFICATE OF DEATH

25725

FILED SEP 1 1942 318

Registration District No.

Primary Registration District No.

State File No.

Registrar's No.

70223

000  
17  
9  
73  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis Mo.  
(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:  
Chronosed dead City Hosp #2  
(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 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL") 20 9  
(d) Street No. 2510 N. Leffingwell  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19  
year 1942 hour 6 minute 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 \_\_\_\_\_

Broncho Pneumonia

Due to 107

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

Other conditions 107  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(a) Means of injury 5

23. Signature Thomas F. Calloway or other \_\_\_\_\_  
Address Deputy Coroner Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Carrie Edna Burk

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

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced D

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Aug 25 1940  
(Month) (Day) (Year)

8. AGE: Years 1 Months 11 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Edward Burk

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

14. Maiden name Loretta Olive

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

16. (a) Informant Loretta Burk

(b) Address 2510 N. Leffingwell

17. (a) Burial (b) Date thereof Aug 24, 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director McDowell

(b) Address 124 N. Taylor Ave

19. (a) Aug 27 1942 (b) J. F. Bredek  
(Date of local registration) (Registrar's signature)

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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.....

.....*William C. McDowell*....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*William C. McDowell*

Licensed Embalmer No.....*2114*.....

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, above space should be left blank.**