

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15719  
Registrar's No. 896

FILED APR 23 1944  
Registration District No. 3069

Primary Registration District No. 3069

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

1. PLACE OF DEATH:

(a) County ST LOUIS  
(b) City or town RICHMOND HEIGHTS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST MARYS HOSPITAL  
(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)

3. (a) PRINT FULL NAME ALVINA MARIE BURKE

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife JAMES J. BURKE 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased APRIL 1ST 1870  
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation AT HOME

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

12. Name PETER C. LEIMER.

13. Birthplace GERMANY 4 (City, town, or county) (State or foreign country)

14. Maiden name ANTONIA LEBRECHT

15. Birthplace GERMANY 4 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Virginia Burke Murphy

(b) Address 86 Aberdeen Pl.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR. 15-1944 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETARY

18. (a) Signature of funeral director E. J. Mulvaney

(b) Address 516 S. Delmar St.

19. (a) APR 15 1944 (Date received local registrar) (b) E. J. Mulvaney (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis 9th  
(c) City or town UNIVERSITY CITY (If outside city or town limits, write "RURAL")  
(d) Street No. 86 ABERDEEN PL. 3 (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 13 year 1944 hour 10 minute 40 A.M.

21. I hereby certify that I attended the deceased from 9/12/41 to 4/13/44

that I last saw him/her alive on 4/13/44 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage left with right side paralysis Cardio-Vascular disease with

Due to Cardio-Vascular disease with Hypertension

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

Other conditions 106a 18 (Include pregnancy within 3 months of death)

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

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident-Fall 4/5/44

(b) Date of occurrence 4/5/44 1 31k

(c) Where did injury occur? 86 Aberdeen Pl., University-City (City or town) (County) (State) (City)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yard of home

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

23. Signature E. J. Mulvaney (M. D. or other)

Address 1004 No. Theatre Bldg. Date signed 4/14/44

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**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 W. G. Farris

Licensed Embalmer No. 3384

P. O. Address St Louis

**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.**