

FILED SEP 1 1945 318

Primary Registration District No. 1003

Registrar's No. 2100

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:
3327 N. Florissant 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

3. (a) PRINT FULL NAME Elizabeth M. Burke

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

4. Sex F./ 5. Color or race W. 6. (a) Single, widowed, married, divorced. M./

6. (b) Name of husband or wife Thomas E. Burke 6. (c) Age of husband or wife if alive 55

7. Birth date of deceased March 27th, 1890
(Month) (Day) (Year)

8. AGE: 56 Years Months 5 Days 0
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name William Ingram
 13. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Hallahan
 15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Thomas E. Burke
 (b) Address 3327 N. Florissant Ave.

17. (a) Burial (b) Date thereof 8-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jensen Barnacks

18. (a) Signature of funeral director Arthur J. Donville
 (b) Address 3840 Lindell Blvd.

19. (a) AUG 28 1945 J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 030
 (c) City or town St. Louis 17 20
(If outside city or town limits, write "RURAL")
 (d) Street No. 3327 N. Florissant Ave. 9
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 27th
 year 1945 hour 7 minute 10 a.m.

21. I hereby certify that I attended the deceased from Aug. 24, 1945 to Aug. 27, 1945;
 that I last saw her alive on Aug. 25, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 week

Due to previous cerebral hemorrhage
2 years ago.

Due to _____

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

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) Means of injury _____

23. Signature W. H. Just (M. D. or other) mo
 Address 2807 N. Grand Ave. Date signed 8/27/45

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Kimmel

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.