

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 23 1946
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

42207
State File No. 10855
Registrar's No.

Registration District No. _____ Primary Registration District No. _____

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:
St. John's 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 33 Years
years, months or days)

3. (a) PRINT FULL NAME Edmund Burke
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Josephine Burke 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Nov. 11 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 1 8 hr. _____ min.

9. Birthplace Dont Know Connecticut
(City, town, or county) (State or foreign country)

10. Usual occupation Life Insurance

11. Industry or business Officer Of Company

MOTHER FATHER

12. Name Patrick Burke

13. Birthplace Dont Know Connecticut
(City, town, or county) (State or foreign country)

14. Maiden name Lottie McCrone

15. Birthplace Dont Know Connecticut
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Josephine Burke

(b) Address Park Plaza Hotel

17. (a) Burial (b) Date thereof 12-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Franklin Blvd

19. (a) DEC 17 1946 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. Park Plaza Hotel
220 N. Kingshighway
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16
year 1946 hour 5 ³⁰ minute 0 P. M.

21. I hereby certify that I attended the deceased from Dec 16
1946 to Dec 16 1946
that I last saw him alive on Dec 16 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure
Duration _____

Due to Chronic rheumatic heart disease

Due to _____
Other conditions (Include pregnancy within 3 months of death) 95

Major findings: Of operations _____

Of autopsy _____
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) (e) Means of injury _____

23. Signature James H. Reedy (M. D. or other) _____

Address 1501 Locust Date signed 12/17/46

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

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 Lundell

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.