

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18039

FILED JUN 9 1950

State File No. 4759

BIRTH NO. 36522-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1759

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 17 - 2606 S. Grand Blvd.	
3. NAME OF DECEASED (Type or Print) Christopher		4. DATE OF DEATH May 30, 1950	
5. SEX M.		6. COLOR OR RACE W.	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.		8. DATE OF BIRTH May 26, 1950	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil	
11. BIRTHPLACE (State or foreign country) St. Louis		12. CITIZEN OF WHAT COUNTRY? nil	
13a. FATHER'S NAME Robert Burke		13b. MOTHER'S MAIDEN NAME Elizabeth Schirmer	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Robert Burke, 2606 S. Grand Blvd.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, atherosclerosis, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tracheoesophageal fistula</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>congenital abnormality</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19. DATE OF OPERATION May 28, 1950		19b. MAJOR FINDINGS OF OPERATION Tracheoesophageal Fistula	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 756.2	
22. I hereby certify that I attended the deceased from <u>May 26, 1950</u> , to <u>May 30, 1950</u> , that I last saw the deceased alive on <u>May 30, 1950</u> , and that death occurred at <u>2:25 A. M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE Houston Glenn Kellogg		23b. ADDRESS MD. 4349 Westmunder St. Louis Mo	
23c. DATE SIGNED May 30, 1950		24. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 31, 1950	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. MAY 31 1950		REGISTRAR'S SIGNATURE J. B. Sasater	
25. GENERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly		ADDRESS 3840 Lindell Blvd.	

STATEMENT BY LICENSED EMBALMER

not

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

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.