

FILED JAN 10 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43318

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11422

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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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2239	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Little Sisters of Poor So		d. STREET ADDRESS (If rural, give location) 23 2220 So 12th St.	

3. NAME OF DECEASED (Type or Print)	a. (First) Howard	b. (Middle) William	c. (Last) Burk	4. DATE OF DEATH (Month) (Day) (Year) 12 10 52
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Abt. 1878	9. AGE (In years last birthday) (Months) (Days) (Hours) (Mins.) Abt 74
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Fireman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Philadelphia	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Howard Burk	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lillian Burk
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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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Burk 1029 Roxbury Lane
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION Lemay Mo		INTERVAL BETWEEN ONSET AND DEATH yr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Dis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) St. Louis, Mo
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200
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22. I hereby certify that I attended the deceased from Jan 1952, to _____, 19____, that I last saw the deceased alive on 12/10/52, and that death occurred at 3P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R A Mezera M.D.	23b. ADDRESS St. A. MEZERA, M. D. 639 NO. GRAND ST. LOUIS, MO	23c. DATE SIGNED 12/11/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-13-52	24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo
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DATE REC'D BY LOCAL REG. DEC 11 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Dale A. Sturman

Licensed Embalmer No. 4533

P. O. Address St Louis Mo

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.