

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30662**

FILED AUG 25 1953

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2199

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY OR TOWN <u>Lemay</u>		c. CITY OR TOWN <u>Lemay</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>144 W. Etta Ave.</u>		e. STREET ADDRESS (If rural, give location) <u>144 West Etta Ave. 4870</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Daisy</u> b. (Middle) <u>Burke</u> c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 8, 1953</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 1, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>New Jersey</u>
13a. FATHER'S NAME <u>Fred W. Osborne</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Geo. T. Burke, 9920 Meadow Ave.</u> ADDRESS _____
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Paralysis Agitans</u> 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 _____	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>July 20, 1953</u> , to <u>Aug. 8, 1953</u> , that I last saw the deceased alive on <u>Aug. 8, 1953</u> , and that death occurred at <u>11 a. m.</u> , from the causes and on the date stated above.		23. DATE SIGNED <u>Aug 10, 53</u>	
23a. SIGNATURE <u>Walter R. Dwyer, M.D.</u> (Degree or title) _____		23b. ADDRESS <u>960 1/2 South Broadway</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 11, 1953</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Concordia Lutheran</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-10-53</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harriet R. Dwyer-Mendler</u> ADDRESS <u>Undertaking Co. 7420 Michigan</u>	

Cranford
96 S. Broadway

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.....
Signature of Student Embalmer

Signed *W. G. Peterson*

Licensed Embalmer No. *376*

P. O. Address *7420 Mich*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.