

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17095

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4196**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give town OR St. Louis, Mo.)		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN University City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital.		e. STREET ADDRESS (If rural, give location) 6819 Raymond			
3. NAME OF DECEASED (Type or Print)		a. (First) Elizabeth		b. (Middle)	
		c. (Last) Burch		4. DATE OF DEATH (Month) (Day) (Year) May 8, 1954.	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH Mar. 25, 1893.		9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (City and State or Foreign Country) St. Paul, Minn.		12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Michael Kirchmaier	
14. NAME OF HUSBAND OR WIFE Joseph E. Burch.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO.		16. SOCIAL SECURITY NO. None.	
17. INFORMANT'S SIGNATURE OR NAME Joseph E. Burch.		ADDRESS 6819 Raymond Ave.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 152x	
22. I hereby certify that I attended the deceased from Dec 1, 1953, to May 8, 1954 , that I last saw the deceased alive on May 8, 1954 , and that death occurred at 1223P m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Edwin P. Meiners, M.D.		23b. ADDRESS 6651 Enright		23c. DATE SIGNED 5/9/54.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 5-9-54		24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		DATE REC'D BY LOCAL REG. MAY 10 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 emb

by me, or by, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
No Embalm
Larry Meyer
Licensed Embalmer No.....

P. O. Address.....

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (F
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.