

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 12 1955

State File No. **38073**
Registrar's No. **10438**

BIRTH NO. **79965-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke's Hospital		e. STREET ADDRESS (If rural, give location) 6 1431 1/2 Clara	
3. NAME OF DECEASED (Type or Print) a. (First) Baby b. (Middle) Boy c. (Last) Burke			4. DATE OF DEATH (Month) (Day) (Year) October 17, 1955
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH October 17, 1954
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min. 30
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State, or Foreign Country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Leroy Reed Burke	
13b. MOTHER'S MAIDEN NAME Nellie Sue Turce		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)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Leroy Reed Burke		18. ADDRESS St. Louis, Mo.	
19. 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital atelectasis INTERVAL BETWEEN ONSET AND DEATH 4 hr. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 762.5	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Oct 17, 1955 , to 19 , that I last saw the deceased alive on Oct. 17, 1955 , and that death occurred at 9:30 m., from the causes and on the date stated above.	
23a. SIGNATURE L. S. Jones, M.D.		23b. ADDRESS 5535 Delmar	
23c. DATE SIGNED 10/20/55		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 11-30-55		24c. NAME OF CEMETERY OR CREMATORY Anatomical Bldg	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Funeral Home Mortuary Service	
DATE REC'D BY LOCAL REG. NOV 30 1955		REGISTRAR'S SIGNATURE Carl Smith	

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.....

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