

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29281**
Registrar's No. **6966**

FILED AUG 26 1957

BIRTH NO. _____ 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 St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY OR TOWN St. Louis, Missouri	c. LENGTH OF STAY (In this place) 22 days	c. CITY OR TOWN East St. Louis 312^og	
d. FULL NAME OF HOSPITAL OR INSTITUTION 34 St. Mary's Inf.		d. STREET ADDRESS (If rural, give location) 32 1023 Paradise Avenue	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Marie	b. (Middle)	c. (Last) Burks	(Month) July	(Day) 24,	(Year) 1957

5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 15, 1896	9. AGE (In years last birthday) 61	10. MONTHS 1	11. DAYS 9	12. HOURS 	13. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (State or foreign country) Alabama	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE James Burks
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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. None	17. INFORMANT'S SIGNATURE OR NAME James Burks	ADDRESS 1023 Paradise Ave
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral embolism.		INTERVAL BETWEEN ONSET AND DEATH One week
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial thrombi. DUE TO (c) Arteriosclerotic heart disease		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary infarction		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 420.0 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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)
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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?
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22. I hereby certify that I attended the deceased from 9/24/1956, to 7/24/1957, that I last saw the deceased alive on 7/24, 1957, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Sydney A. Fraser M.D.	23b. ADDRESS 4242 E. Easton	23c. DATE SIGNED 7/25/57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-26-57	24c. NAME OF CEMETERY OR CREMATORY East St. Louis, Ill.	24d. LOCATION (City, town, or county) (State) East St. Louis, Ill.
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DATE REC'D BY LOCAL REG. JUL 26 57	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE P. Q. Criggler	ADDRESS 1036 Tudor Ave.
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed P. J. Crigger

Signed
Student Embalmer

Not Embalmed

Licensed Embalmer No. 3346

P. O. Address St Louis Ill

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.