Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 26 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33303 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8739

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hosp. #1 — Length of stay in 1b 25
d. STREET ADDRESS (If outside, give location) 2720 SO. 7th — Reside on Farm Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN ST. LOUIS, MO. 2720 SO. 7th. — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 2720 SO. 7th — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last BURKE
4. DATE OF DEATH Month Aug. Day 19 Year 1957
5. SEX Male
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8/19/57
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 2 Min. 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (City and state or country) ST. LOUIS, MO
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LAWRENCE BURKE
14. MOTHER'S MAIDEN NAME DARLENE MC GEE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Address ST. LOUIS CITY HOSP. RERORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congenital Atelectasis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 7625
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8/19/57 3:50p to 8/19/57 - 6:10p and last saw her/him alive on
Death occurred at 8/19/57- 6:10 p. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] M.D.
22b. ADDRESS 1515 Lafayette Ave.
22c. DATE SIGNED 9/10/57

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE 9-30-57
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS Rowland - Aker 4104 Manchester
25. DATE RECD. BY LOCAL REG. SEP 18 57
26. REGISTRAR'S SIGNATURE J Earl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

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. (
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.