Health, & Welfare Public Service

S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-031345
STATE FILE NUMBER

FILED SEP 12 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2218

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. John's Village — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3326 Eminence — Length of stay in 1b 2½ years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN St. John's Village 4210 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 3326 Eminence — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Andrew Middle M. Last Burke
4. DATE OF DEATH Month Day Year August 24, 1958

5. SEX Male
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH November 2, 1886
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman
10b. KIND OF BUSINESS OR INDUSTRY St. Louis Fire Dept.
11. BIRTHPLACE (City and state or country) St. Louis, Missouri.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Michael Burke
13b. MOTHER'S MAIDEN NAME Augusta Nolde
14. NAME OF HUSBAND OR WIFE Nil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) Nil
16. SOCIAL SECURITY NO. 498-16-0169
17. INFORMANT Mary Diederich, Address 1916 Obear Avenue.

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) Chr. Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 1 yr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio-Sclerosis — 2 yrs.
DUE TO (c) 4221
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral hemorrhage
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 3-5-57, to 8/24/58 and last saw her/him alive on 8/24/58
Death occurred at 3:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Maurice A Diehn MD
22b. ADDRESS 8924 St Charles Rd St Louis 14, Mo
22c. DATE SIGNED 8/25/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 8-27-58
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis, Missouri.

24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG. 8-25-58
26. REGISTRAR'S SIGNATURE Herbert R. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Lawrence O. Gerke

Licensed Embalmer No. 4979

P. O. Address St. Louis, M

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.