

DED

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, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO		Length of stay in 1b 93 DAYS	c. CITY OR TOWN Wellston
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6318 ETZEL AVE.

3. NAME OF DECEASED (Type or print) First MIDDLE Last BARTLEY BURKE			4. DATE OF DEATH Month Day Year OCTOBER 8 1960	
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/20/90	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Emp. of Public Service Co.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) IRELAND	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME BARTLEY BURKE	13b. MOTHER'S MAIDEN NAME BRIDGET HANNEGAN	14. NAME OF HUSBAND OR WIFE ANN BURKE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WW I	16. SOCIAL SECURITY NO. 493-10-9273	17. INFORMANT ANN BURKE	6318 ETZEL Address ST LOUIS, MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) PULMONARY EDEMA		
DUE TO (b) CONGESTIVE HEART FAILURE		
DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE 4200		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHRONIC PYELONEPHRITIS WITH UREMIA AND HYPERTENSION		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. attended the deceased from 7/25/60 to 10/8/60 and last saw him alive on 10/8/60 Death occurred at 9:05 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Howard H. Eoenberg MD M.D.	22b. ADDRESS VAH, ST LOUIS, MISSOURI	22c. DATE SIGNED 10/8/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-11-60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR J.W. Clark F.H. 1125 Hodiamont Ave.	25. DATE RECD. BY LOCAL REG. OCT 10 1960	26. REGISTRAR'S SIGNATURE Road Smith M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St Louis

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.