

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6002

AMENDED

FILED JUL 7 1961

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>                |  | c. CITY OR TOWN <b>St. Louis</b>  |  |
| Length of stay in 1b  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>2825 Thomas</b>   |  |
| Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                               |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |

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|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Hamp</b> Middle Last <b>BURK</b> | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>24</b> Year <b>61</b> |
|--|---|

|                       |                                  |   |                                    |                                     |                                |                              |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--------------------------------|------------------------------|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>Negro</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5-30-93</b> | 9. AGE (last birthday)<br><b>68</b> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HR<br>Hours Min. |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|--------------------------------|------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> | 11. BIRTHPLACE (City and state or country)<br><b>Arkansas</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |
|---|--|---|--|

|                                      |   |   |
|--------------------------------------|---|---|
| 13a. FATHER'S NAME<br><b>Unknown</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Tryphine Burk</b> |
|--------------------------------------|---|---|

|   |                                     |                                       |                               |
|---|-------------------------------------|---------------------------------------|-------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> | 16. SOCIAL SECURITY NO.<br><b>2</b> | 17. INFORMANT<br><b>Tryphine Burk</b> | Address<br><b>2825 Thomas</b> |
|---|-------------------------------------|---------------------------------------|-------------------------------|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate with Metastasis</b> |            | INTERVAL BETWEEN ONSET AND DEATH<br><b>Undet.</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) | <b>177x</b>                                       |
|  | DUE TO (c) |   |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Uremia due to Urinary Obstruction, Generalized/</b> | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m. | Month, Day, Year |
|---|------------------|

|  |  |                              |        |       |
|--|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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. I attended the deceased from <b>6-21-61</b> to <b>6-24-61</b> and last saw him alive on <b>6-24-61</b>            |
| Death occurred at <b>9:25</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. |

|                                      |                                |  |                                    |
|--------------------------------------|--------------------------------|--|------------------------------------|
| 22a. SIGNATURE<br><i>[Signature]</i> | (Degree or title)<br><b>MD</b> | 22b. ADDRESS<br><b>2601 N. Whittier Street</b> | 22c. DATE SIGNED<br><b>6-26-61</b> |
|--------------------------------------|--------------------------------|--|------------------------------------|

|   |           |  |   |
|---|-----------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal 6-29-61</b> | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATOR<br><b>Father's Dickson</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Mo.</b> |
|---|-----------|--|---|

|   |                                |  |   |
|---|--------------------------------|--|---|
| 24. FUNERAL DIRECTOR<br><b>Thomas Jackson</b> | ADDRESS<br><b>2741 Dickson</b> | 25. DATE RECD. BY LOCAL REG.<br><b>JUN 28 1961</b> | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |
|---|--------------------------------|--|---|

STATE AMENDED

DOCUMENT

SHOULD READ

NEW NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

General  
of the  
of the

10 45 0  
10 45 0  
10 45 0

John  
Statement of the student to the board

**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 Leroy W. Dammister

Licensed Embalmer No. 4523  
P. O. Address 4251 Washu

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.