

FILED APR 13 1942

Registration District No. ....

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St John's Hospital** 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 Mon.**  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **7. 000**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **5477 Queens Ave.**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **James T. Burke**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **W.**

6. (b) Name of husband or wife **Lottie Burke** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **Oct. 12th., 1874**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**67** **5** **14** hr. .... min.

9. Birthplace **St. Louis** **Mo.** 0  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Ball Player**

11. Industry or business.....

MOTHER FATHER { 12. Name **John Burke**  
13. Birthplace **Ireland** 4  
(City, town, or county) (State or foreign country)  
14. Maiden name **Catherine McGary**  
15. Birthplace **Ireland** 4  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Joseph Burke**  
(b) Address **4526 Ruskin Ave.**

17. (a) **Burial** (b) Date thereof **3-30-1942**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur Nonnelly**  
(b) Address **3840 Lindell Blvd.**

19. (a) **MAR 28 1942** **J. F. Bredrek**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar.** day **26th.**  
year **1942** hour **12** minute **55** p. M.

21. I hereby certify that I attended the deceased from **3/20/42**, 19... to **3/12/42**, 19...  
that I last saw him alive on **3/26/42**, 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia - lobar** Duration

Due to **Pneumonia Type 17. 10h**

Due to.....

Other conditions **Parkinsons disease** 10  
(Include pregnancy within 3 months of death)

Major findings: **108**  
Of operations.....  
Of autopsy.....

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?.....  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place)  
(e) Means of injury.....

23. Signature **O. O. Park** (M. D. or other)  
Address **Humboldt Rd.** Date signed **3/27/42**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

17  
9

848