

REC'D NOV 16 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

34309
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003** Registered No. **9295**
(c) City **ST. LOUIS** (d) Street No. **FIRMIN DES LOBE HOSPITAL** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **ALFRED W. BURKHARDT.**

(a) Residence, No. **3606 MARCUS AVE.** St. **10** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **MALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **MARRIED**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **JENN BURKHARDT.**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **JUNE 7-1885.**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **53 4 17**
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **INSURANCE SALESMAN**
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) **7 WKS. A.G.S.** 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **LEBANON, Mo.**

FATHER 13. NAME **GEO. BURKHARDT.**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **GERMANY**

MOTHER 15. MAIDEN NAME **CAROLINE KOOPER**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **GERMANY**

17. INFORMANT (ADDRESS) **Mrs. Jenn Burkhardt
3606 Marcus Ave.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **CALVARY CEMETERY** DATE **OCT. 27, 1938**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **John M. Schumacher
4836 National Bldg.**

20. FILED **OCT 26 1938** **J. F. Briedeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct. 24, 1938**

22. I HEREBY CERTIFY, That I attended deceased from **10-12-1938**, to **10-24-1938**
I last saw him alive on **10-23-1938**. Death is said to have occurred on the date stated above, at **145 A.** m.
The principal cause of death and related causes of importance were as follows:

Septicemia from nodule on left index finger (Staphylococcus alb.) 10-5-38
Septicemia developed from Tularemia-cause of Tulare -
Other cause unknown

Name of operation **none** Date of.....
What test confirmed diagnosis? **lab.** Was there an autopsy? **no.**

23. If death was due to external causes (violence), fill in also the following:
Not known Date of injury **1938**
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **Not known if any.**
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify **Charles P. Heron**, M. D.
(Signed) **Charles P. Heron**
(Address) **3720 Washington St. St. Louis, Mo.**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. 3880

P. O. Address _____

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 this body is not embalmed, above space should be left blank.