

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

48839
State File No. _____
Registrar's No. 2416

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
200 Viehl ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life (Specify whether
years, months or days) 2

8. (a) PRINT FULL NAME Leona M. Burkard

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 15 1917
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
23 4 6 _____ hr. _____ min.

9. Birthplace St. Louis Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Beauty Operator

MOTHER FATHER

11. Industry or business _____
12. Name Joseph Burkard

13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Leona Schittler
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Leona Burkard
(b) Address 200 Viehl ave.

17. (a) Burial (b) Date thereof Dec. 24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parklawn Cemetery

18. (a) Signature of funeral director C. Hoffmeister H. & L. Co.
(b) Address 7814 S. Broadway

19. (a) DEC 22 1940 (b) H. A. Meyer M.D. D.D.P.
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Lemay
(If outside city or town limits, write "RURAL")
(d) Street No. 200 Viehl ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21
year 1940 hour 7 minute 20 M.

21. I hereby certify that I attended the deceased from Dec 14
Dec 21 1940 _____ 19____;
that I last saw her alive on Jan 20 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary Tuberculosis Duration 3 Wks

Due to R.B.C

Due to 23

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
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 D. S. Hurlbert (M. D. or other) 3
Address 3628 8th Date signed Dec 22 1940

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

360845-2
Done 7891
R10523
3823 H. C. Kline

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 Edmund H. Leubinger

Licensed Embalmer No. 4049

P. O. Address 6464 Chippewa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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