

FILED APR 28 1943 8  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Alexian Brothers Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3885 Humphrey Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William H. Burklin

3. (b) If veteran, name war None

3. (c) Social Security No. 486-22-2069

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced, Widower

6. (b) Name of husband or wife Late Anna Burklin

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 16th 1864  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>10</u>	<u>3</u>	_____ hr. _____ min.

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

10. Usual occupation Pressman

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Henry Burklin

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Louise Kios

15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Burklin

(b) Address 3885 Humphrey Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-22-43  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Paul's Churchyard

18. (a) Signature of funeral director Kriegshauser Mortuary

(b) Address 4228 So. Kingshighway Blvd.

19. (a) \_\_\_\_\_ (b) J. F. Breda  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19th  
year 1943 hour 7 minute P.M. M.

21. I hereby certify that I attended the deceased from 4/8, 1943, to 4/19, 1943  
that I last saw him in alive on 4/19, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral

Due to Cerebrum of ascending colon

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: H/S

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 J. F. Breda (M. D. or other) \_\_\_\_\_

Address 3885 So. Kingshighway Date signed 4/24/43

2810 H. av. Astoria  
11-1

**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 *Richard W. Swenson*

Licensed Embalmer No. *4007*

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, fact should be so stated above.**