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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____

REC'D MAY 18 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 4359

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:
925 Geyer Ave.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
(Specify whether years, months or days)
 In this community 35 Years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
 (d) Street No. 925 Geyer Ave.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME ALBERT AUGUST BURKHARDT

3. (b) If veteran, name war No 3. (c) Social Security No. 493-10-8864A

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

6. (b) Name of husband or wife Eleanor 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Oct. 18th 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>6</u>	<u>20</u>	_____ hr. _____ min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Motorman (Street Car)

11. Industry or business Retired (4 years)

12. Name August Burkhardt

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

14. Maiden name Unknown

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Eleanor Burkhardt

(b) Address 925 Geyer Ave.

17. (a) Burial (b) Date thereof May 11, 43.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

*18. (a) Signature of funeral director A. H. M. Laughlin

(b) Address 2301 Lafayette Ave.

19. (a) MAY 11 1943 (b) J. F. Budeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8th
 year 1943 hour 3 minute 50 a.m.

21. I hereby certify that I attended the deceased from Feb 23 1943 to May 7 1943
 that I last saw him alive on May 7 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
 Due to Hypertension
 Due to arteriosclerosis
 Other conditions myocarditis, pharyngitis
(Include pregnancy within 3 months of death)

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

Major findings: no operation
 Of operations _____
 Of autopsy no autopsy

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) no
 (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 W. H. Cuthers (M. D. or other) _____
 Address 406 Carlton Bldg Date signed May 9, 43

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

MOTHER FATHER

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

L. R. Cooper

Licensed Embalmer No.

3636

P. O. Address

2317 Lafayette

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.