

V. S. No. 2
FORM-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____

FILE JUN 19 1943

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **5443**

1. PLACE OF DEATH:

(a) County _____

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

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

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Randolph**

(c) City or town **Red Bud**
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ **2**

3. (a) PRINT FULL NAME **William H. Burkhardt**

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

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

6. (b) Name of husband or wife **Louise Burkhardt** 6. (c) Age of husband or wife if alive **51** years

7. Birth date of deceased **June 26 1888**
(Month) (Day) (Year)

8. AGE: Years **54** Months **11** Day **20** If less than one day
.....hr.min.

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

10. Usual occupation **Vice-President**

11. Industry or business **Banking**

12. Name **John M. Burkhardt**

13. Birthplace **Burksville Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Louise Woll**

15. Birthplace **Monroe County Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Louise Burkhardt**

(b) Address **Red Bud, Illinois**

17. (a) **Burial** (b) Date thereof **6/15/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Red Bud, Illinois**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc.**

(b) Address **4700 Washington Blvd.**

19. (a) **JUN 18 1943** (b) **J. F. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **14**
year **1943** hour **7** minute **15** A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Murcid Greenness of Stomach

Due to _____

Due to **Hb**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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)

23. Signature **Albert H. Hoppe** (M.D. or other)

Address **Red Bud, Illinois** Date signed **6/14/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Albert G. Hopper*

Licensed Embalmer No..... *2971*

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.