

Registration District No. 47  
**FILED MAR 15 1944**

Primary Registration District No. 3008

State File No. \_\_\_\_\_  
Registrar's No. 416

1. PLACE OF DEATH

(a) County Callaway  
(b) City or town Fulton  
(c) Name of hospital or institution: State Hosp # 12  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution June 11-239  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME

John Birtler  
3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased Sept 18 1900  
(Month) (Day) (Year)

8. AGE: Years 43 Months 4 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace MO (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER  
12. Name Chas Birtler  
13. Birthplace MO (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
14. Maiden name DK  
15. Birthplace MO (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
16. (a) Informant Record  
(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 7 7 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Burying

18. (a) Signature of funeral director Byrd Brown  
(b) Address 3704 Leinweg Ave. St. Louis 90

19. (a) Feb 5 1944 (b) Joan M. Mankoff  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis  
(c) City or town Robertson  
(If outside city or town limits, write "RURAL") 2  
(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2  
year 1944 hour 20 minute 0 M.

21. I hereby certify that I attended the deceased from 11-25, 1943 to 2-2, 1944

that I last saw him alive on 2-1, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Paritic  
syphilis

Due to Syphilis

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

Other conditions (Include pregnancy within 3 months of death) 30g

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature K.E. Sherard (M. D. or other) \_\_\_\_\_  
Address Fulton MO Date signed 2/2/44

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date Filed 3-14-44

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 Ronald V. Atkin

Licensed Embalmer No. 2842

P. O. Address 3644 Finn

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, fact should be so stated above.