

7. S. No. 2
OM-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32111

State File No.

8846

FILED OCT 23 1944

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

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: St. Anthony 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 30 years 0 (Specify whether years, months or days)

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. 109 Waller
(If rural, give location) NR
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Catherine Burkhardt

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Henry Burkhardt 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased October 13, 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 0 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife at home

11. Industry or business _____

12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Henry Burkhardt
(b) Address 109 Waller
17. (a) Burial (b) Date thereof Oct. 19, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director Fendler Und. Co.
(b) Address 7420 Michigan Avenue

19. (a) OCT 18 1944 (Date received local registrar) J. F. Braddock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16 year 1944 hour 5 minute 30 P M.

21. I hereby certify that I attended the deceased from Oct 16 to Oct 16 1944
that I last saw aw alive on Oct 16 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis chronic } ?
Nephritis chronic } ?
Due to Arteriosclerosis } ?
Due to _____

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) (e) Means of injury _____

23. Signature Paul Brown (M. D. or other) MD
Address Paul Brown Date signed Oct 18

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

179

MOTHER FATHER

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

121

Signature no

W. Warner
Paul Brown Blvd
818 Olive

JAN 22 1953

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 W. C. Morris

Licensed Embalmer No. 3360

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.