

No. 2
12-45
17-39
X47070

FILED SEP 24 1946
REGISTRATION DISTRICT NO. **318**

STANDARD CERTIFICATE OF DEATH

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **7835**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis City, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital - Max C. Starkloff Memorial**
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
Street No. **4926 Claxton Ave**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **FRED H. BURGGRABE**

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

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

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

7. Birth date of deceased **October 11, 1875**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	10	28	hr. min.

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

10. Usual occupation **Cabinet maker**

11. Industry or business _____

MOTHER FATHER

12. Name **Fred Burggrabe**

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

14. Maiden name **Augusta Dueker**

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

16. (a) Informant **Frank A. Burggrabe**

(b) Address **4926 Claxton Ave**

17. (c) **Burial** (b) Date thereof **9/11/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Math Hermann & Son**

(b) Address **2161 East Fair Ave**

19. (a) **SEP 10 1946** (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **8th**
year **1946** hour **5:43** minute **P** M.

21. I hereby certify that I attended the deceased from **9/5/46**
to **Sept. 8th, 1946**
that I last saw him alive on **Sept. 8th, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia**

Due to **Arteriosclerosis of Kidney**

Due to **10/8**

Other conditions **Lobar Pneumonia left lobe**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **Left lower lobe Pneumonia**

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 **George B Smith** **9/9/46**
Address **215 Lafayette** or other _____

Date signed _____

0-0-0
717
79
0

Duration
2 wks

1 wk

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 *Raymond F. Hoernemann*

Licensed Embalmer No. *4266*

P. O. Address *St. Louis, Mo*

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.