

No. 2  
-12-45  
-17-39  
I X47070

FILED APR 8 1947

State File No. \_\_\_\_\_

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3231**

1. PLACE OF DEATH:

(a) County **ST. LOUIS MO**

(b) City or town **ST. LOUIS MO**

(c) Name of hospital or institution: **2027 A. EAST WARNE AVE.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **LIFE**  
In this community \_\_\_\_\_ years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS**

(c) City or town **ST. LOUIS**  
(If outside city or town limits, write "RURAL.")

(d) Street No. **2027 A. EAST WARNE AVE.**  
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country **NONE**

3. (a) PRINT FULL NAME **HENRY V. BURKHART**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAR.** day **24<sup>TH</sup>**  
year **1947** hour **5:07** minute **P.** M.

4. Sex **MALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **PAULA BURKHART**

6. (c) Age of husband or wife if alive **66** years

7. Birth date of deceased **MCH 27<sup>TH</sup> 1879**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **March 1/47**  
to **March 24**, 19 **47**

that I last saw him alive on **March 24**, 19 **47**  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE: Years **67** Months **11** Days **27**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to **Repetitive Carcinoma**

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

9. Birthplace **ST. LOUIS MO**  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation **RETIRED**

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

11. Industry or business **MARBLE SETTER**

Of autopsy \_\_\_\_\_

12. Name **VALENTINE BURKHART**

22. If death was due to external causes, fill in the following:

13. Birthplace **GERMANY**

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

14. Maiden name **GENEVIEVE PROBST**

(b) Date of occurrence \_\_\_\_\_

15. Birthplace **GERMANY**

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(b) Address **2027 A. East Warne Ave**

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

17. (a) **BURIAL** (b) Date thereof **MCH 27-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

23. Signature **Cecil H. Sample** (M. D. or other) \_\_\_\_\_  
Address **4144 N. Grand** Date signed **3/24/47**

18. (a) Signature of funeral director **Brockland Und. Co**

(Date received local registrar) **MAR 26 1947** (Registrar's signature) **J. F. Brodeck**

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

MOTHER FATHER

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

**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.....

Licensed Embalmer No. *4057*

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.**