

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24983  
State File No. \_\_\_\_\_

FILED AUG 13 1948

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Saint Louis  
(b) City or town South Kinloch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Carson Road S of Scott  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town South Kinloch  
(If outside city or town limits, write "RURAL")  
(d) Street No. Carson Rd s of Scott  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Charles Burgott  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Wid  
6. (b) Name of husband or wife Amelia Burgott  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 6, 1860  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>88</u>	<u>0</u>	<u>27</u>	hr. _____ min.

Birthplace Calloway Co., Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer (retired)

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

12. Name Tom Burgott

13. Birthplace Calloway Co., Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Bays

15. Birthplace Calloway Co., Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant M.C. Burgott

(b) Address South Kinloch 21, Mo.

17. (a) Burial (b) Date thereof 7 Aug 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Hill, Mo.

18. (a) Signature of funeral director Boyd Bros

(b) Address So. Kinloch, Mo.

19. (a) 8-7-48 (b) Beaulay Shaylor  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 10  
year 48 hour \_\_\_\_\_ minute 30 P. M.

21. I hereby certify that I attended the deceased from 7-6-48 to 8-2-48, 1948  
that I last saw him alive on 8-2-48  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic renal disease  
Duration \_\_\_\_\_

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

Other conditions Mitralis in heart  
(Include pregnancy within 3 months of death) 3 200

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

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? \_\_\_\_\_

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

23. Signature John Johnson (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 8/10/48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A FINGERPRINT

**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.....

*Edward A Flynn*

Licensed Embalmer No.....

*4444*

P. O. Address.....

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**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.

*Lu 2664*