FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 23 1948

Registration District No. 3187

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34934

Primary Registration District No. 3066

Registrar's No. 2

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Kirkwood, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 9623 Hi-way 66 1
(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 96

(c) City or town Kirkwood, Mo. 4
(If outside city or town limits, write "RURAL")

(d) Street No. 9623 Hi-way 66 3
(If rural, give location) 0

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME George W. Burgmeyer

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

4. Sex Male O

5. Color or race White

6. (a) Single, widowed, married, divorced Widower 2

6. (b) Name of husband or wife Mary

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

7. Birth date of deceased Oct. (Month) 25 (Day) 1877 (Year)

8. AGE: Years 72 | Months 11 | Days 10 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Retired

11. Industry or business .....

FATHER
12. Name George W. Burgmeyer 9
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Sophia Burkhardt 11
15. Birthplace Unknown (City, town, or county) Germany (State or foreign country)

16. (a) Informant Irene Van Cleave
(b) Address 9623 Hi-way 66, Kirkwood, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/48 (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director Wacker-Helderle
(b) Address 3634 Gravois Ave.

19. (a) 10-8-48 (Date received local registrar) (b) Cecil a Shoop MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5
year 1948 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct 2, 1948, to Oct 5, 1948
that I last saw him alive on Oct 5, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma 1	9 months
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 0

23. Signature Trentin M Gaines M D (M. D. or other)
Address 508 N. Kirkwood Rd Kirkwood, Mo Date signed 10/7/48

(Licensed Embalmer's Statement on Reverse Side)

OCT 5 1956

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 Robert C Wheeler

Licensed Embalmer No. 2178

P. O. Address Arkansas Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 317 Primary Registration District No. 3066 Registrar's No. 2319

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Kirkwood
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(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 (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME George W. Burgmeyer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 25 (Month) 1871 (Day) (Year)

8. AGE: Years 72 Months 11 Days 18 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 51
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach with metastasis to liver.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 46 B

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 Quentin M Gaines (M. D. or other)
Address Date signed 11/9/48

SUPPLEMENTARY

S-34934