

5. No. 300  
10. 48

FILED FEB 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 811

BIRTH NO. _____		REG. DIST. NO. <u>116</u>		PRIMARY REG. DIST. NO. <u>3020</u>		Registrar's No. <u>19</u>			
1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Gastonade</u>					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Washington, Mo.</u> )		c. LENGTH OF STAY (in this place) <u>3 mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hermann</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Frances Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>118 West Second St.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Carrie</u>			b. (Middle) _____		c. (Last) <u>Burkhardt</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 30 1949</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 31, 1862</u>		9. AGE (In years and birthday) <u>86</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>29</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Hermann, Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>no</u>	
13a. FATHER'S NAME <u>Fred Vallet</u>			13b. MOTHER'S MAIDEN NAME <u>Monica Yaley</u>			14. NAME OF HUSBAND OR WIFE <u>Fred Burkhardt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Vera Witthaus Hermann, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive heart disease</u> ANTECEDENT CAUSES DUE TO (b) <u>Diabetes</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Thrombophlebitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>  <u>Unknown</u>  <u>3 mos.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>None</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR _____					
22. I hereby certify that I attended the deceased from <u>Nov. 1948</u> , to <u>Jan. 30, 1949</u> , that I last saw the deceased alive on <u>Jan. 29, 1949</u> , and that death occurred at <u>8:30 A. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>John B. Ryan M.D.</u>				23b. ADDRESS <u>Hermann, Mo.</u>			23c. DATE SIGNED <u>1/30/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Jan. 30/49</u>		24c. NAME OF CEMETERY OR-CREMATORY <u>City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Hermann Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Jan. 31, 1949</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		99		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature] Hermann Mo.</u>			

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

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
District Health Officer No. 91  
District File No. 10149  
Date Filed

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed  \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2044

P. O. Address Hermann, 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.