

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26717

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1967

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Baden Station		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Baden Station	
c. LENGTH OF STAY (in this place) 7 yrs		4010	
d. FULL NAME OF HOSPITAL OR INSTITUTION 11347 Larimore Rd.,		d. STREET ADDRESS (If rural, give location) 11347 Larimore Rd.,	

3. NAME OF DECEASED (Type or Print)	a. (First) Amelia	b. (Middle)	c. (Last) Burkhardt	4. DATE OF DEATH (Month) (Day) (Year) July 20th, 1952
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Feb 14th 1869	9. AGE (In years) (Month) (Day) (Year) 83	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) O'Fallon, Ill	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME ? Frazier	13b. MOTHER'S MAIDEN NAME Friedrika Obst	14. NAME OF HUSBAND OR WIFE Otto Burkhardt
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Lena Huelsebusch, 11347 Larimore	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Central Nervous System. Polio		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Due to (b) Paralysis Due to (c) Arterio Sclerosis DUE TO (c) 331X		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **July 1, 1952**, to **July 19, 1952**, that I last saw the deceased alive on **July 18, 1952**, and that death occurred at **6:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. A. Knight M.D.	23b. ADDRESS 2201 N. Broadway St. Louis	23c. DATE SIGNED 7-21-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/23/52	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery St. Louis Co., Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 7-22-52	REGISTRAR'S SIGNATURE Herbert R. Donke M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Diedrich F. Home, 8319 Hallsferry	ADDRESS
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WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Eleanor Poirice

Licensed Embalmer No.

3403

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.