

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27171

FILED JUL 23 1953

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 546 Registrar's No. 1862

ADD X  
of

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

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Overland Mo.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis</b> 2237	
c. LENGTH OF STAY (In this place) <b>1 Month</b>		d. STREET ADDRESS (If rural, give location) <b>2664 Nebraska Av</b> 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lackland Nursing Home</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Mary</b> b. (Middle) <b>Madeline</b> c. (Last) <b>Burkhardt</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 6 1953</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb 24 1872</b>
9. AGE (In years last birthday) <b>81</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S</b>
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Leonard (Deceased)</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Edward Burkhardt 3321 Osage Street</b>
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) <b>Cerebral apoplexy</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic myocarditis 6 months</b> DUE TO (c) 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"/>		352X	
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 <b>July 1, 1953</b> , to <b>July 5, 1953</b> , that I last saw the deceased alive on <b>July 5, 1953</b> , and that death occurred at <b>7:30</b> p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>M. A. Selman, M.D.</b>		23b. ADDRESS <b>5816 North Concor</b>	23c. DATE SIGNED <b>July 6 1953</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>7/8/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>S S Peter &amp; Paul</b>	24d. LOCATION (City, town, or county) (State) <b>St Louis Missouri</b>
DATE REC'D BY LOCAL REG. <b>7-6-53</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Donda, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Moydell Funeral Home 1926 Allen Av</b>	

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**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 *Reinhold K. Lehmann* .....

Licensed Embalmer No. *3395* .....

P. O. Address .....

**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.