

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20274**
Registrar's No. **4588**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 4588	
1. PLACE OF DEATH COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS, MISSOURI		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL				e. STREET ADDRESS (If rural, give location) 6418 A. Idaho Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE		b. (Middle) WARREN		c. (Last) BURGMAN		4. DATE OF DEATH (Month) (Day) (Year) MAY 21, 1954	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 4-2-1866	
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) Nebraska	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Isaac Burgman			13b. MOTHER'S MAIDEN NAME Nancy Thomas			14. NAME OF HUSBAND OR WIFE Bertha Burgman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bertha Burgman 6418 A. Idaho Ave			
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) Arteriosclerotic heart disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome due to cerebral arteriosclerosis.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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 <input checked="" type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200			
22. I hereby certify that I attended the deceased from 4-12-54 , 19____, to 5-21-54 , 19____, that I last saw the deceased alive on 5-21-54 , 19____, and that death occurred at 6:15A m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) C. G. Lauer MD				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 5-21-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-24-1954		24c. NAME OF CEMETERY, OR CREMATORY New St. Marcus Cemetery		24d. LOCATION (City, town, or county) (State) 7901 Gravois Ave Mo	
DATE REC'D BY LOCAL REG. MAY 24 1954		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Ziegenhain Bros 6409 Gravois Ave			

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.....
Signature of Student Embalmer

Signed.....
Paul M. Seymour

Licensed Embalmer No. 434

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.