

FILED APR 30 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14492**
Registrar's No. **3825**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. 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 township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Park Lane Hospital		e. STREET ADDRESS (If rural, give location) 10 3123 N. Newstead 210%	

3. NAME OF DECEASED (Type or Print) a. (First) Frank	b. (Middle) J.	c. (Last) Burger	4. DATE OF DEATH (Month) (Day) (Year) April 16, 1956
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH Nov. 13, 1892	9. AGE (In years last birthday) 63	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) Cook	10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Steven J. Burger	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Helen Burger
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I	16. SOCIAL SECURITY NO. 497-03-6643	17. INFORMANT'S SIGNATURE OR NAME Lottie Deppe	ADDRESS 3317 Arlington Ave.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 wk
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331x	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (m.)	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 **4-8-56**, 19**56**, to **4-16-56**, 19**56**, that I last saw the deceased alive on **4-15-56**, 19**56**, and that death occurred at **12:25 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clarence R. Lane M.D.	23b. ADDRESS 706 Walton	23c. DATE SIGNED 4-16-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-18-56	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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DATE REC'D BY LOCAL REG. APR 17 1956	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd
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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.....
Signature of Student Embalmer

Signed..... *G. W. Wilkins*

Licensed Embalmer No..... *25*

P. O. Address..... *M. H.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.