

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014765

STATE FILE NUMBER

2 3636

MAY 1 1959

Registration District No.

Primary Registration District No.

Registration No.

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3622 Robert R. Kowalek</b>		d. STREET ADDRESS (If outside, give location) <b>3622 Robert R. Kowalek</b>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Louise Burghardt</b>			4. DATE OF DEATH Month Day Year <b>Apr. 10, 1959</b>		
--	--	--	--	--	--

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1879</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	--	---	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>Hungary</b>	12. CITIZEN OF WHAT COUNTRY? <b>usa</b>
--	--	--	--

13a. FATHER'S NAME <b>Nick Kolacheck</b>	13b. MOTHER'S MAIDEN NAME <b>unk.</b>	14. NAME OF HUSBAND OR WIFE <b>Nick Burghardt</b>
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. Theresa Morarin 5609 Potomac</b>
---	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) <b>Arteriosclerosis</b>	
	DUE TO (c) <b>421.0</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
--

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	---

21. I attended the deceased from 1950 to Mar 1 1959 and last saw her alive on Mar 12 1959  
Death occurred at 9 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Robert J. Fide M.D.</b>	22b. ADDRESS <b>7110 Michigan Ave</b>	22c. DATE SIGNED <b>4/10/59</b>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>4-13-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, MO.</b>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <b>Southern Funeral Home 8322 S. Grand, St. Louis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>APR 14 59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith. M.D.</b>
--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr Tebe  
7118 Mulberry  
Tel 4 PM

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 *David Van Gorman* .....

Licensed Embalmer No. *4242* .....  
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.