

**FEDERAL BUREAU OF INVESTIGATION**  
**U.S. DEPARTMENT OF JUSTICE**  
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**U.S. DEPARTMENT OF JUSTICE**

UNRECORDED  
 UNINDEXED

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH** **-60-031969**

FILED VS AUG 17 1960 **318** **1003** **7917** STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis, Mo.</b>		Length of stay in 1b <b>30 yr. 3 mo 18 days</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3887a Humphrey St.</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>EDWIN</b> Middle <b>C.</b> Last <b>BURKLIN</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>8th,</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-3-91</b>	9. AGE (last birthday) <b>69 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>formerly: Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printer</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>William H. Burklin</b>		13b. MOTHER'S MAIDEN NAME <b>Anna ?</b>		14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 4/1918 to 5/1918</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Nellie M. Burklin, 4517a Jamieson, St. Lou</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Bilateral pneumonia</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Congestive cardiac failure</b>	
DUE TO (c) <b>+34.1</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Renal insufficiency</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <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 **April 21, 1930** to **Aug. 8, 1960** and last saw <sup>him</sup> alive on **Aug. 8, 1960**  
 Death occurred at **9:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. Blasquez, M.D.</i> (Degree or title)		22b. ADDRESS <b>5400 Arsenal St.</b>	22c. DATE SIGNED <b>8-9-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8/11/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Churchyard</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>

24. FUNERAL DIRECTOR <b>Hoffmeister Colonial Mortuary</b> <b>646 Chippewa Street, St. Louis, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 10 1960</b>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mjb*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bill Chesser

Licensed Embalmer No. 4764

P. O. Address St Louis

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