

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

31431

1. PLACE OF DEATH

County St Charles
Township.....
City St Charles (No.) (St. Ward)

Registration District No. 757
Primary Registration District No. 3036

File No.
Registered No. 142

2. FULL NAME

William Burkemper
(a) Residence No. St. Ward. Old Missouri Mo
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) -

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 19-1917

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	11	6	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Old Missouri Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Lawrence Burkemper

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Old Missouri Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Barbara Hennings

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Old Missouri Mo
(STATE OR COUNTRY)

14. INFORMANT L. George Burkemper
(Address) Old Missouri Mo

15. FILED 9/16, 1928 By G. Bloebaum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 16 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1928,
that I last saw him alive on Sept 16, 1928 and that death occurred, on the date stated above, at 2 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intracranial infection of
meninges
1223
11801
(duration) yrs. mos. da. 2 da.

CONTRIBUTORY (SECONDARY) none
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, Old Missouri

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 9/16/28

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? operation
(Signed) Ben J. Hubickas, M.D.

(Address) St Charles Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Old Missouri Mo DATE OF BURIAL 19

20. UNDERTAKER Chas R Bloebaum ADDRESS Old Missouri Mo

Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

—Every item of information should be carefully checked and verified before being placed in print. —
OF DEATH in plain terms so the public can understand the true nature of the case.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County St. Charles Registration District No. 737 File No. 149
 Township Primary Registration District No. 3036 Registered No. 479
 City (No.) St. Ward)

2. FULL NAME William X BURKEMPER
 (a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED s (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR)
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer
 9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
 10. NAME OF FATHER
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)
 14. INFORMANT (Address)
 15. FILED 9/16 1928 Hy C. Blebsam REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 16 1928
 17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw him alive on 19..... and that death occurred, on the date stated above, at.....
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 19 (Address)
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 N. B.—Exact statement of OCCUPATION is very important. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important.

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