

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

Do not use this space.

23543

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1008

City.....

St. Louis

(No. *St. Louis City*)

File No.

Registered No.

7059

Ward)

2. FULL NAME

*Albert Burkhardt*

(a) Residence, No. *4348 Page*

St. *11*

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

*Male*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

*June 3, 1916*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

*15*

*0*

*24*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

*School Boy*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

*St. Louis*

(STATE OR COUNTRY)

10. NAME OF FATHER

*Conrad Burkhardt*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

*St. Louis*

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

*Elizabeth Gidenhart*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

*Dakfield*

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

*Mrs. C Burkhardt, 4348 Page Blvd.*

15.

FILED

*27, 1931*

*Max O. Starnitz*

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

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

*June 26, 1931*

17.

*No Physician attended*

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 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:

*Septic Pneumonia following shock & Burns 2nd Degree received while under shower bath*

CONTRIBUTORY

(SECONDARY)

*181 Accident*

(duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH.....

DATE OF.....

20. WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed).....

*J. W. Ferrel, M.D.*

(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

*St. Peters Cemetery*

*June 27, 1931*

20. UNDERTAKER

*Shepard Funeral Home*

ADDRESS

*1167-69 Hamilton*

N. B.—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. Exact statement of OCCUPATION is very important.

Did a house  
burn up in  
this case?

Buy new house  
by water from [unclear]

**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..... Registration District No. 796  
 Township..... Primary Registration District No. 1863  
 City St. Louis (No.)..... St. .... Ward)

File No. ....  
 Registered No. 7039  
 St. .... Ward)

**2. FULL NAME**

Albert Burkhardt  
 (a) Residence, No. .... St. .... Ward.  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) D

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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER FATHER 13. NAME

14. BIRTHP. (STATE)

15. MAIDEN

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 406-4 131 May 6 1931 Max L. Stackloff Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/26, 1931

22. I HEREBY CERTIFY, That I attended deceased from ....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Septic pneumonia  
following shock  
from 2nd degree  
accident  
 Other contributory causes of importance:

Date of onset

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify.....

(Signed)....., M. D.  
 (Address).....

N. B.—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. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY