

FILED JAN 31 1945

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4266 San Francisco Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **1** (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Elizabeth M. Buerges**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Leo F. Buerges** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **September 16 1889**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	55	4	7	hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Peter Niggemeier**

13. Birthplace **St. Charles Missouri** (City, town, or county) (State or foreign country)

14. Maiden name **Catherine Radel** (City, town, or county) (State or foreign country)

15. Birthplace **Germany** (City, town, or county) (State or foreign country)

16. (a) Informant **Leo F. Buerges**

(b) Address **4266 San Francisco Ave.**

17. (a) **Burial** (b) Date thereof **1/25/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Stroet-Carroll**

(b) Address **4600 Natural Bridge Ave.**

19. (a) **JAN 24 1945** (b) **J. J. Bredeek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **17**
(d) Street No. **4266 San Francisco Ave.** (If rural, give location) **9/10**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **23**
year **1945** hour **2** minute **12 A** M.

21. I hereby certify that I attended the deceased from **Jan 23 1945**
that I last saw her alive on **Jan 23 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Hypertension**
Cardiovascular disease
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations **None**
Of autopsy **None**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence **None**
(c) Where did injury occur _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work _____ (Specify type of place) (e) Means of injury _____
3. Signature **James J. Pyle** (M. D. or other) **MO**
Address **6125 13th St** Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Sheldon Callier

Licensed Embalmer No. 3882

P. O. Address 4600 Natural Bridge

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 this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb

X38930

Registration District No. 218

Primary Registration District No. 1003

Registrar's No. 734

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community.....
years, months or days)

3. (a) PRINT FULL NAME Elizabeth M. Burger
 3. (b) If veteran, name war.....
 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Sept 16
(Month) (Day) (Year)

8. AGE: Years 55 Months 4 Days 20 (Unless than one day) min. 30

9. Birthplace St. Louis, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....
(City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof.....
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address 7 1945
 19. (a) FEB 7 1945 (b) J. F. Bredeh
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town.....
(If outside city or town limits, write "RURAL")
 (d) Street No.....
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 21
 year 1945 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....; that I last saw him..... alive on....., 19.....; and the death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
 Of operations.....

Of autopsy.....

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?.....
(Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

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