No. 2
-8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3657

State File No.

Registration District No. 335 Primary Registration District No. 6-11-8-4492 Registrar's No.

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Oran
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott
(c) City or town Oran 100
(If outside city or town limits, write "RURAL")
(d) Street No. — 4
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country —

3. (a) PRINT FULL NAME Anton Burger
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Aug (Month) 28 (Day) 1870 (Year)

8. AGE: Years	Months	Days	If less than one day
76	4	28	— hr. — min.

9. Birthplace (City, town, or county) Germany (State or foreign country)
10. Usual occupation Sufflenheim Germany
11. Industry or business Farmer
FATHER
12. Name Louis Burger
13. Birthplace — Germany (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Katherine Enderwine
15. Birthplace — Germany (City, town, or county) (State or foreign country)
16. (a) Informant Bernice Sutman
(b) Address Oran Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/47 (Month) (Day) (Year)
(c) Place: burial or cremation Oran Mo
18. (a) Signature of funeral director
(b) Address Heisserer Funeral Home Oran Mo
19. (a) 2/3-47 (Date received local registrar) (b) (Registrar's signature) H. Eichman

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25 year 1947 hour 5 minute P M.
21. I hereby certify that I attended the deceased from 1946 to 1/25 1947 that I last saw him alive on 1/24 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Endocarditis	9
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

92D

PHYSICIAN
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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature J A Cline (M. D. or other)
Address Oran Mo Date signed 1/26/47

305 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 247-197
Date Filed 2-9-47

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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 this body is not embalmed, fact should be so stated above.

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Tet

Registration District No. 335 Primary Registration District No. 4492 Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Oran
(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)

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

3. (a) PRINT FULL NAME Anton Burger

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 28 (Month) (Day) 1870 (Year)

8. AGE: Years 76 Months 4 Days 29 If less than one day br. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Day 25
year 1947 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-3657