

FILED NOV 28 1947 **318**

Primary Registration District No. **1003**

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

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: **Alexian Brothers Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 week**
(Specify whether

In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Ludwig Burger**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **492-10-9089**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Anna** 6. (c) Age of husband or wife if alive **53** years
7. Birth date of deceased **August 6th, 1890**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	57	3	13hr.min.

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

10. Usual occupation **Machinist**

11. Industry or business **Hotze & Sons**

MOTHER FATHER

12. Name **Lendaline Burger**
13. Birthplace **Germany**
(City, town, or country) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or country) (State or foreign country)

16. (a) Informant **Anna Burger**
(b) Address **3523 S. Spring, St. Louis, Mo.**

17. (a) **Burial** (b) Date thereof **11/21/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New St. Marcus Cemetery**

18. (a) Signature of funeral director **Wacker-Keldahl & Co.**
(b) Address **3634 Gravois, St. Louis, Mo.**

19. (a) **NOV 20 1947** (b) **J. F. Brueck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3523 S. Spring Avenue**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **19th**
year **1947** hour **1** minute **00** A. M. P. M.

21. I hereby certify that I attended the deceased from **11/14** 19**47** to **11/19** 19**47**
that I last saw **him** alive on **11/18** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Brain Tumor**
Due to **Unqualified**

Due to **57**
Other conditions (include pregnancy within 3 months of death)

Major findings: **Increase intra-cranial pressure**
Of autopsy

Duration
2-3 hrs
PHYSICIAN
Underline the cause of 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 **Edmund A. Amorek** (M. D. or other).....
Address **Beaumont Med Bldg** date signed **11/19/47**

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 _____

Frank J. G. Gland
Licensed Embalmer No. *2675*
P. O. Address *St Louis 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.