FILED MAY 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17130

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4231

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST LOUIS MO 1
c. LENGTH OF STAY (in this place): LIFE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3625 GASCONADE

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: ITTV
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST LOUIS 17
d. STREET ADDRESS (If rural, give location): 3625 GASCONADE 5

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): JOHN M. BURKART

4. DATE OF DEATH (Month) (Day) (Year): 5-10-1949

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 11/13/1888
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months 5, Days 27 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): JEFFERSON Co MO
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: JOHN G BURKART
13b. MOTHER'S MAIDEN NAME: MARY POHLE
14. NAME OF HUSBAND OR WIFE: JOSEPHINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME: JOSEPHINE BURKART — ADDRESS: 3625 GASCONADE

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Paralysis Agitans — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Bronchial pneumonia — 5 days
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 87C
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 332X

22. *I hereby certify that I attended the deceased from* Jan, 1945, *to* 5-9-, 1949 *that I last saw the deceased alive on* 5/10, 1949 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph L. Arrow
23b. ADDRESS: 4065 S Grand
23c. DATE SIGNED: 5/11-49

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 5/13/49
24c. NAME OF CEMETERY OR CREMATORY: SUNSET
24d. LOCATION (City, town, or county) (State): ST LOUIS Mo

DATE REC'D BY LOCAL REG.: MAY 12 1949
REGISTRAR'S SIGNATURE: J. B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: BURKART-YEAGER — ADDRESS: 3801 Dunnica

(Licensed Embalmer's Statement on Reverse Side)

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

4231

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~~ me

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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