

FILED SEP 3 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26757

BIRTH NO. _____ REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 5430 Registrar's No. _____

| | | | |
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| 1. PLACE OF DEATH a. COUNTY FRANKLIN | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY JEFFERSON | |
| b. CITY (If outside corporate limits, write RURAL and give town or township) RURAL CENTRAL | | c. CITY (If outside corporate limits, write RURAL and give township) RURAL MERAMEC TOWNSHIP | |
| c. LENGTH OF STAY (in this place) 2 Weeks | | d. STREET ADDRESS (If rural, give location) NEAR BYRNESVILLE 0500 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION OWN HOME ROBERTSVILLE-RR | | | |

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|-------------------------------------|------------------------|----------------------|--------------------------|--------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) ANNA | b. (Middle) L | c. (Last) BURKART | 4. DATE OF DEATH (Month) (Day) (Year) 8-16-1954 |
|-------------------------------------|------------------------|----------------------|--------------------------|--------------------------------------------------------|

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|-----------------|-------------------------------|-----------------------------------------------------------------------|--------------------------------------|-------------------------------------------|---------------------|-------------------|-------------------|------------------|
| 5. SEX F | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH JULY 14-1896 | 9. AGE (In years last birthday) 68 | 10. MONTHS 1 | 11. DAYS 2 | 12. HOURS | 13. MIN. |
|-----------------|-------------------------------|-----------------------------------------------------------------------|--------------------------------------|-------------------------------------------|---------------------|-------------------|-------------------|------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | 11. BIRTHPLACE (State or foreign country) CEDAR HILL MO | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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|------------------------------------------|---------------------------------------------|---------------------------------------------------|
| 13a. FATHER'S NAME GERHART FICKEN | 13b. MOTHER'S MAIDEN NAME EMMA MEIER | 14. NAME OF HUSBAND OR WIFE EDWARD BURKART |
|------------------------------------------|---------------------------------------------|---------------------------------------------------|

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|-----------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------|--------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT'S SIGNATURE OR NAME Edw E Burkart | ADDRESS Catawissa |
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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--|---------------------------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Anterior cranial Central Hemorrhage | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 3 1/2 wks |
| 18. ANTECEDENT CAUSES <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Vascular Hypertension | | | years |
| 18. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Total General paralysis | | | 3 1/2 yrs. |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? 331X YES <input type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|--------------------------------------------------------------------------------------|

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|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 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) |
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|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------|

22. I hereby certify that I attended the deceased from **June 2, 1954** to **8-16, 1954**, that I last saw the deceased alive on **8-15, 1954** and that death occurred at **7:00** p.m., from the causes and on the date stated above.

| | | |
|---------------------------------------------------------------|----------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) W. E. Kitchener, M.D. | 23b. ADDRESS 51-Clair Ave | 23c. DATE SIGNED 8-18-54 |
|---------------------------------------------------------------|----------------------------------|---------------------------------|

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|---------------------------------------------------------|-------------------------------|------------------------------------------------------------|-----------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE AUG 19, 1954 | 24c. NAME OF CEMETERY OR CREMATORY ST MARTINS. CEM. | 24d. LOCATION (City, town, or county) (State) DITTMER MO |
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|----------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------|---------------------------------|
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 8-18-54 | REGISTRAR'S SIGNATURE William C. ... | 25. FUNERAL DIRECTOR'S SIGNATURE Brimmer Fun. Home | ADDRESS Howa Springs Mo. |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

non-injury - in view

0360

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed John H. Brimmer

Licensed Embalmer No. 1470

P. O. Address Home Springs 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.