

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1918

FILED JUN 30 1955

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4848**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo., township)		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis, Co. ⁸⁷
d. FULL NAME OF HOSPITAL OR INSTITUTION 6610 Colorado		STREET ADDRESS (If rural, give location) 319 W Felton ⁴⁸⁷⁰	
3. NAME OF DECEASED (Type or Print) a. (First) Anna		b. (Middle)	c. (Last) Burkart
4. DATE OF DEATH (Month) 6 (Day) 1 (Year) 1955			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9/27/1897
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months 8 Days 4	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done if not at work at time of death, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Maxville, Mo.,
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Joseph Vogel		13b. MOTHER'S MAIDEN NAME Mary Ziegelmeier	14. NAME OF HUSBAND OR WIFE Fred Burkart
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Fred Burkart ADDRESS 319 W Felton
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) Acute dilation of heart ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Cardio-vascular disease DUE TO (c) Ca of ovaries & generalized metastasis to liver & omentum	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	INTERVAL BETWEEN ONSET OF DEATH 2 hrs. several yrs 6 Mon.
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4222	
22. I hereby certify that I attended the deceased from 9-1 , 19 54 , to 6-1 , 19 55 , that I last saw the deceased alive on 6-1 , 19 55 , and that death occurred at 10 A. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Lucia S. Creelies M.D.		23b. ADDRESS 75 1/2 Levee Ferry St	23c. DATE SIGNED 6-7-55
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 6/4/55	24c. NAME OF CEMETERY OR CREMATORY Resurrection	24d. LOCATION (City, town, or county) (State) St. Louis Co Mo.
DATE REC'D BY LOCAL REG. JUN 3 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Edward Fuchs ADDRESS 5611 O. Grand	

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

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.....
Signature of Student Embalmer

Signed *Bill E. Drames*

Licensed Embalmer No. *479*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.