

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030284

FILED VS AUG 18 1959

2 7354

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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|--|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | c. CITY OR TOWN Marquand | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1821 Oregon Ave. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|--|--|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Jacob Middle _____ Last Burkart | | | 4. DATE OF DEATH Month August Day 6 Year 1959 | | | |
|--|--|--|---|--|--|--|

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|-----------------------|----------------------------------|---|---------------------------------------|-------------------------------------|--|--|--|--|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12/10/1869 | 9. AGE (last birthday) 89 | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | |
|-----------------------|----------------------------------|---|---------------------------------------|-------------------------------------|--|--|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Madison Co., Mo. | 12. CITIZEN OF WHAT COUNTRY U.S. |
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| 13a. FATHER'S NAME Andrew Burkart | 13b. MOTHER'S MAIDEN NAME Mary Haines | 14. NAME OF HUSBAND OR WIFE Frances 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 Address Lucian Patterson, 1821 Oregon |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Diabetes Mellitus | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Pericarditis Aneurysm | |
| DUE TO (c) 260x | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ |
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|--|--|---|--------------------------|---------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION Marquand | COUNTY Madison | STATE Mo. |
|--|--|---|--------------------------|---------------------|

21. I attended the deceased from **4/20/59** to **8/6/59** and last saw him alive on **8/6/59**.
Death occurred at **9 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|-------------------|---------------------------------------|-----------------------------------|
| 22a. SIGNATURE Otto C. Hanss M.D. | (Degree or title) | 22b. ADDRESS 3012 Lafayette | 22c. DATE SIGNED 8/7/59 |
|---|-------------------|---------------------------------------|-----------------------------------|

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|---|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 8-9-59 | 23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Cemetery | 23d. LOCATION (City, town, or county) Marquand Mo. |
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| 24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. | ADDRESS | 25. DATE RECD. BY LOCAL REG. AUG 7 '59 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Elmer R. Padwe

Licensed Embalmer No. 4077

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.