

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-012403**

**FILED VS MAR 17 1960**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 2713**

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3500 SO. COMPTON</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY _____  c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>3500 SO COMPTON</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> First Middle Last <b>FRANCES BURKARD</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>MARCH 6 1960</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>JULY 3, 1868</b>
<b>9. AGE (last birthday)</b> <b>91</b>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>AT HOME</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>GERMANY</b>
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U-S-A</b>		<b>13a. FATHER'S NAME</b> <b>WILLIAM WAGNER</b>	
<b>13b. MOTHER'S MAIDEN NAME</b> <b>ANNA SCHLOTTMAN</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>JOSEPH J. BURKARD</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>	<b>17. INFORMANT</b> Address <b>AGNES DONOVAN 3745 MERAMEC</b>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Collapse</b> DUE TO (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>422.2</b> Conditions, if any, which gave rise to above cause: (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>acute Rectal Hemorrhage - Piles</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____			
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b> _____ <b>STATE</b> _____
<b>21. I attended the deceased from</b> <b>Feb. 27-1960</b> to <b>death</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>March 5-1960</b> Death occurred at <b>939 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
<b>22a. SIGNATURE</b> (Degree or title) <b>Dr. Leo P. Young M.D.</b>		<b>22b. ADDRESS</b> <b>2621 1/2 Jefferson St. Louisville</b>	<b>22c. DATE SIGNED</b> <b>March 7/60</b>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>23b. DATE</b> <b>MAR 9, 1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>CALVARY CEM.</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>ST. LOUIS, MO</b>
<b>24. GENERAL DIRECTOR</b> ADDRESS <b>Thomas Hutia 2906 Gravois</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>MAR 8 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Paul Smith, M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2-31-21, Tins

**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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grand

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.