

**STANDARD CERTIFICATE OF DEATH**

State File No. **42605**

**FILED DEC 28 1953**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 1117-A

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Unknown</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town Rural, S. Campbell Twp. OR TOWN Rural, S. Campbell Twp.)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Unknown</b>	
c. LENGTH OF STAY (in this place) <b>1yr 7mos 5das</b>		8390	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Medical Center for Federal Prisoners</b>		d. STREET ADDRESS (If rural, give location) <b>Unknown</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Herbert</b> b. (Middle) <b>John</b> c. (Last) <b>Burgman</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 16, 1953</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>
7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>4-17-94</b>
9. AGE (In years last birthday) <b>59</b>	# UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Gustave Burgman</b>	13b. MOTHER'S MAIDEN NAME <b>Karoline Dahlke</b>	14. NAME OF HUSBAND OR WIFE <b>Johanna Karhl Burgman</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>1918-1920</b>	17. INFORMANT'S SIGNATURE OR NAME <b>FILE: M.C.F.P., Springfield, Missouri</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH (Minutes)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute pulmonary edema</b>	DUPLICATE TO (b) <b>Arteriosclerotic heart disease</b>		<b>Years</b>
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	DUPLICATE 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 <b>4200</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	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 May 12, 1952, to Dec. 16, 1953, that I last saw the deceased alive on Dec. 16, 1953, and that death occurred at 8:48 a.m., from the causes and on the date stated above.

23a. SIGNATURE <b>E. C. Rinck</b> (Degree or title) <b>M. D., Clinical Director</b>	23b. ADDRESS <b>Medical Center for Federal Prisoners, Springfield, Mo.</b>	23c. DATE SIGNED <b>12-17-53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>12/18/1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>- - - - -</b>
24d. LOCATION (City, town, or county) (State) <b>Austin, Minnesota</b>		

DATE REC'D BY LOCAL REG. <b>12-21-53</b>	REGISTRAR'S SIGNATURE <b>Edith Williams</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>AYRE-GOODWIN FUN'L SERVICE, Spgfld,</b>
--	---	---

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

No. 300  
10-48

390

JAN 5 19

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*[Handwritten Signature]*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4 5 9 4

P. O. Address Springfield, 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.