

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

J. H. 27377

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Kaw Primary Registration District No. _____
 City K. C. Mo. (No. 1632 Summit) St. _____ Ward _____

File No. _____
 Registered No. 1735

2. FULL NAME

Edward Raymond Burkitt
 (a) Residence No. 1632 Summit St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 3 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 16 - 1919

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	7	9	7	x

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolboy
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) K. C. Mo.
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER John C. Burkitt

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Mellicor

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Missouri

14. INFORMANT John E. Burkitt
 (Address) 1632 Summit

15. FILED 9-24-27 M. M. Crowe
 REGISTRAR act

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-23-1927

17. Deputy Coroner
 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ in.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Myocarditis
115A
93A

CONTRIBUTORY (SECONDARY) Septic sore throat
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT A PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) Henry C. Vaughn, M. D.
9/24, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Grove K. C. Mo. DATE OF BURIAL 9/26 1927

20. UNDERTAKER Mrs. C. L. Forster ADDRESS City

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

