

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

Do not use this space.

30456

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 300
 Township Flaw Primary Registration District No. 1002 Registered No. 300
 City Kansas City (No. St. Joseph's Hosp. St. _____ Ward)

2. FULL NAME

Percy B. Burke
 (a) Residence. No. 307 Jackson St., 10 Ward. (If nonresident give city or town and State)
 (Usual place of abode) 10 (How long in U.S., if of foreign birth? yrs. mos. da.)
 Length of residence in city or town where death occurred yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ada F Burke

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 30, 1882

7. AGE YEARS MONTHS Days If LESS than 1 day, ____ hrs. or ____ min.
45 | 0 | 21

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Blair
 (STATE OR COUNTRY) Iowa

10. NAME OF FATHER Alden W Burke

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

12. MAIDEN NAME OF MOTHER Mattie Evans

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

14. INFORMANT Mrs. Ada F Burke
 (Address) 307 Jackson

15. FILED 10/21, 27 M. M. Caspary REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 21 1927
 17.

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1927, to Oct 21, 1927 that I last saw alive on Oct 20, 1927, and that death occurred, on the date stated above, at 2:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Central Hemorrhage
 (duration) ____ yrs. ____ mos. 2 da.

CONTRIBUTORY Chronic Nephritis
 (SECONDARY) (duration) 5 yrs. ____ mos. ____ da.

18. WHERE WAS DISEASE CONTRACTED 1500
 NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) C. W. Rose, M. D.

*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 Cemetery DATE OF BURIAL 10-25 1927

20. UNDERTAKER A. H. Newcome's Sons ADDRESS K. C., Mo.

M. D.—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.

WHITE PAPER, WITH GRAYING INK—THIS IS A PERMANENT RECORD

St. John's
Ben. 4191.

1- m.

NOV 3 1941