

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

Do not use this space.

5164  
726

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
Township East Primary Registration District No. \_\_\_\_\_  
City Kansas City (No. Kansas City General Hosp) Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Burke David  
(a) Residence. No. 1413 Madison St. Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 35 yrs. mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? yrs. mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 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) Sept 15<sup>th</sup> 1892

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>35</u>	<u>5</u>	<u>2</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work City Fireman  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER Michael Burke

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

12. MAIDEN NAME OF MOTHER Margaret Hanigan

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

14. INFORMANT Reverend Clerk  
(Address) K.C. General Hosp.

15. FILED 2-18-28 M.M. Crowe REGISTRAR  
asst.

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-17 1928

17. I HEREBY CERTIFY, That I attended deceased from 2-16 1928, to 2-17 1928 that I last saw him alive on 2-17 1928, and that death occurred, on the date stated above, at 2:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Lobar Pneumonia  
tox.  
75 B (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
CONTRIBUTORY Chronic Alcoholism  
(SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED 1010  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS P. E. Williams  
(Signed) \_\_\_\_\_, M. D.  
(Address) Supt K.C. Genl Hosp

\*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 St Marys Cem DATE OF BURIAL 2/20/28

20. UNDERTAKER H. J. Mayberry ADDRESS City

N. 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

