

MAY 27 1930

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

Do not use this space.
13210

1. PLACE OF DEATH

County Lincoln
Township Bedford
City Waverly (No. _____)

Registration District No. 491
Primary Registration District No. 56574

File No. _____
Registered No. 21
St. _____ Ward _____

2. FULL NAME

Charles Burke Jr

(a) Residence. No. _____ 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

Single

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

Oct 1 - 1912

7. AGE

YEARS 17
16

MONTHS 6

DAYS 28

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St Louis

(STATE OR COUNTRY)

10. NAME OF FATHER

Charles Burke Sr

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Bohemia

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Rose Mares

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Bohemia

(STATE OR COUNTRY)

14. INFORMANT

Charles Burke

(Address)

Troy Mo RFD

15. FILED

4/13/30 30 W.P. Smith

REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR)

April - 28 1930

17.

I HEREBY CERTIFY, That I attended deceased from MAY 31, 1930, to April - 28, 1930, that I last saw h.i.m. alive on April - 27, 1930, and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Infarction

CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr. W. H. ...

511, 1930 (Address) 200th Main St. Charles Mo

*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

DATE OF BURIAL

Bohemia Cemetery

May 1 1930

20. UNDERTAKER

ADDRESS

Kempner Bros Troy Mo

Troy Mo

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

17-6-27

1000

1000

1000

1000

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

ALL INFORMATION RELAYED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Lincoln Registration District No. 491 File No. _____
 Township Bedford Primary Registration District No. 5-654 Registered No. 21
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Charles Bunde
 (a) Residence. No. _____ 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 1-1912

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
X 17 / 6 / X 27 / X / X / X

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

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 (that I last saw him _____ since on _____, 19____, and that death occurred, on the date stated above, at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
 _____ (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

*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.

14. INFORMANT _____ (Address) _____

15. FILED 4/7 1930 W. P. Smith REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____
 _____ 19____

20. UNDERTAKER _____ ADDRESS _____

CAUSE OF DEATH
 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.
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-13210