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

Do not use this space.

4169

File No. 4169
Registered No. 2

1. PLACE OF DEATH
County Schuyler Registration District No. 965
Township 2 Primary Registration District No. 4484
City Lancaster (No. ..... St. ..... Ward)

FEB 21 1931

2. FULL NAME Christinia Burkland

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 26 - 1847

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
83	2	14	

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

9. BIRTHPLACE (CITY OR TOWN) Gottenberg
(STATE OR COUNTRY) Sweden

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known

14. INFORMANT R. L. Burkland
(Address) Lancaster, Mo.

15. FILED Jan 13 1931 W. F. Justice REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1930, to Jan 9, 1931, that I last saw h[illegible] alive on Jan 9, 1931, and that death occurred, on the date stated above, at about 1st P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrage
(CVA (Hemoplegia)
(duration) ..... yrs. ..... mos. 9 ds.
CONTRIBUTORY (SECONDARY) Influenza
(duration) ..... yrs. ..... mos. 15 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) J. J. Drake M. D.
, 19 (Address) Lancaster, 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
I.O.O.F. Cemetery	Jan 11 1931
20. UNDERTAKER John A. Roberts	ADDRESS Lancaster Mo.

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.