

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

Do not use this space.

13686

1. PLACE OF DEATH

County Douglas
Township Clinton
City Quincy (No. _____)

Registration District No. 272
Primary Registration District No. 4165

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

2. FULL NAME

William R. Burkhead

(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. 8 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)

Married

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

Rose Burkhead

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

Jan 20, 1853

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>78</u>	<u>2</u>	<u>28</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lawyer & judge
(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)

Alt. Douglas

10. NAME OF FATHER

Jessie Burkhead

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

North K

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

31

14. INFORMANT

(Address)

Lillian Burkhead

15. FILED

6/1

1931

E. B. Norman

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

4/13 1931

17.

I HEREBY CERTIFY, That I attended deceased from April 6, 1931, to April 13, 1931
that I last saw him alive on April 12, 1931, and that death occurred, on the date stated above, at 9:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Liver
4 1/2 (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

Did an operation precede death W DATE OF 13

19. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) R. M. Norman, M. D.

, 19 (Address) Quincy 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

Quincy Mo

4/15 1931

20. UNDERTAKER

ADDRESS

W. R. Chalkinheard

Quincy 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.

JUN 25 1931

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Douglas
Township ava
City ava (No.)

Registration District No. 272
Prima Registration District No. 4165

File No.
Registered No.
St. Ward

2. FULL NAME

William R. Burphard

(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)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.

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 Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Don't know

14. INFORMANT
(Address)

15. FILED 8/10, 19... E. B. Norman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/13, 1931

17. 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 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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.

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

20. UNDERTAKER ADDRESS

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

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