DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35112

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4087

DEC NOV 14 1939

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Marys Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 25 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 512 East 8th St (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John Burke 620

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased No record (Month) (Day) (Year)

8. AGE: Years about 60 yrs | Months | Days | If less than one day hr. min.

9. Birthplace Penn (City, town, or county) (State or foreign country)

10. Usual occupation Caretaker St Vincent De Paul

11. Industry or business

FATHER
12. Name No record
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Miss Margaret Callaghan

(b) Address 512 East 8th St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-39 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Thomas E Quirk

(b) Address 4316 Troost Ave

19. (a) 10/25/39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 24 year 1939 hour 8.15 A.M. minute M.

21. I hereby certify that I attended the deceased from 10-22-39, 19, to 10-24, 1939; that I last saw him alive on 10-23-, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cancer of head of Pancreas	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Saul Snider (M. D. or other)

Address 221 Plaza Med Bldg K.C. Mo. Date signed 10/20/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

I X19511

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3775

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.