

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.

Registration District No. 582 Primary Registration District No. 4344 State File No. _____ Registrar's No. 42

1. PLACE OF DEATH:
 (a) County MONROE
 (b) City or town PARIS
 (c) Name of hospital or institution: 407 COOPERS AVE
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 70-1-27
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME CHRIS R. BUERK 6220
 8. (b) If veteran, name war 8. (e) Social Security No.

4. Sex MALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife ANNA E. BUERK
 6. (c) Age of husband or wife if alive 68 years
 7. Birth date of deceased SEPT 19, 1869
 (Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 27
 If less than one day hr. min.

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

10. Usual occupation NONE

11. Industry or business

MOTHER FATHER
 12. Name THOS. BUERK
 13. Birthplace GERMANY
 (City, town, or county) (State or foreign country)
 14. Maiden name HENRY SCHLANKE
 15. Birthplace GERMANY
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna Buerk
 (b) Address PARIS, MO

17. (a) BURIAL (b) Date thereof NOV 18, 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation WALNUT GROVE

18. (a) Signature of funeral director Speed & Blaney
 (b) Address PARIS, MO

19. (a) 11-16-39 (b) J. A. Barnett, M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1
 (a) State MO (b) County MONROE
 (c) City or town PARIS
 (If outside city or town limits, write "RURAL")
 (d) Street No. 407 COOPERS AVE.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 14
 year 1939 hour 12 minutes 15 P. M.

21. I hereby certify that I attended the deceased from 1st to 12 Nov 16 1939
 that I last saw him alive on Nov 16 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
 Duration 2 yrs

Due to _____

Due to _____

Other conditions (include pregnancy within 8 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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? 3

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature M. J. Murray (M. D. certifier)
 Address PARIS, MO Date signed 11-16-39

RECEIVED

District Health Officer No. 10

District File Number 12-39-2148

Date Filed DEC 12 1939

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 E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address. Paris, Mo

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

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