

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4758

*JAN 13 1940*

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. Joseph's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 16 Days  
 (Specify whether  
 In this community 22 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. 821 East 42nd Street  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ----- years.

3. (a) PRINT FULL NAME Mr. Charles R. Burrell *640*

3. (b) If veteran, name war No 3. (c) Social Security No. 486-01-1681

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Marr.

6. (b) Name of husband or wife Mrs. Eva Burrell 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased Nov. 24 1888 *84*  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 55 0 20 hr. min.

9. Birthplace Harrison Co., Mo. *0*  
 (City, town, or county) (State or foreign country)

10. Usual occupation Business Manager

11. Industry or business K.C. Blues Baseball Club

12. Name Robert Burrell *9*

13. Birthplace Ill  
 (City, town, or county) (State or foreign country)

14. Maiden name Sarah Oren

15. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. Burrell

(b) Address 821 East 42nd St

17. (a) Burial (b) Date thereof Dec. 17, 1939  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gilman City, Mo.

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) Dec. 16, 1939 (b) M. M. Grooms  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 14th  
 year 1939 hour 11 minutes P. M.

21. I hereby certify that I attended the deceased from Nov 27 1939  
 to Dec 14 1939  
 that I last saw him alive on Dec 14 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Toxic myocarditis  
 Duration

Due to Nephro-renal insufficiency

Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death)

Major findings: Cholelithiasis  
 Of operations

Of autopsy as above noted  
 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? \_\_\_\_\_

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

23. Signature James H. ... (M. D. or other) \_\_\_\_\_

Address 731d Argyle Blvd Date signed 2/15/40

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.

1-5-5-29

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**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 George M. Collins

Licensed Embalmer No. 3839

P. O. Address W.C. 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.**