

STANDARD CERTIFICATE OF DEATH

1002

State File No.

42484

Registrar's No.

4893

Registration District No. 399

Primary Registration District No.

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. 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: Vineyard Park Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Month  
(Specify whether  
 In this community 41 years  
years, months or days)

8. (a) PRINT FULL NAME EDWARD B. BURGESS 622  
 3. (b) If veteran, No name war  
 3. (c) Social Security No. 188

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Clementine  
 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased: October 25, 1898  
(Month) (Day) (Year)

8. AGE: Years 41 Months 2 Days 1 If less than one day  
hr. min.

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

10. Usual occupation Stage Employee

11. Industry or business

MOTHER FATHER  
 { 12. Name Thomas Burgess  
 { 18. Birthplace No Record  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name No Record  
 { 15. Birthplace No Record  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Clementine Burgess  
 (b) Address 338 So. Belmont

17. (a) Burial (b) Date thereof 12-29-39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Spinks & Tobin Co  
 (b) Address K.C. Mo

19. (a) Dec. 28, 1939 (b) M. M. Browne  
(Date received local registrar) (Registrar's signature)

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. 338 South Belmont  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 26  
 year 1939 hour 9 minute 30 M.

21. I hereby certify that I attended the deceased from Nov 26  
Nov 26, 1939 to Dec 26, 1939,  
 that I last saw him alive on Dec 26, 1939,  
 and that death occurred on the date and hour stated above.

Immediate cause of death General Constriction of  
bronchogenic carcinoma Duration 30 days

Due to Bronchogenic carcinoma 6 hrs

Other conditions Pulm fracture of R. Humerus 3 days  
(Include pregnancy within 3 months of death)

Major findings: None 47  
 Of operations

Of autopsy Primary Bronchogenic Carcinoma Multiple Metastasis  
 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 J. S. Sheldahl (M. D. certified)  
 Address 322 Walnut Date signed 12-27-39

K.C. Mo

Burgess

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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 Harold Perry

Licensed Embalmer No. 4097

P. O. Address 20 W Pinewood

**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.