

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18445**
Registrar's No. **469**

Registration District No. **318**

Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Burge Hospital 1325 N. Jefferson**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **ELSON VERL BURKS-620**

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **m** 5. Color or race **wh.** 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 **March 29 40**
(Month) (Day) (Year)

8. AGE: Years Months **1** Days **26** If less than one day hr. _____ min. _____

9. Birthplace **Webster Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Virgil Rafil Burks-**
13. Birthplace **Fordland Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Elizabeth Bryant**
15. Birthplace **Richland Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Virgil Burks-**
(b) Address **Marshfield, Mo. R #3**

17. (a) **Burial** (b) Date thereof **5-26-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Marshfield Mo**

18. (a) Signature of funeral director **Raney Funeral Home**
(b) Address **Marshfield Mo**

19. (a) **5-25-40** (b) **W.E. Haudley MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Marshfield Route # 5**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **25**
year **40** hour **1** minute **40** AM.

21. I hereby certify that I attended the deceased from **5-21-40**, 19____, to **5-25**, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Pertussis** Duration **Weeks**

Due to _____ 9

Due to _____
Other conditions **Ornithobacterium** **1 wk**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? **984**
While at work? _____ (Specify type of place)
(e) Means of injury _____
Signature **Urban Busch** (M. D. or other) _____
Address **Marshfield Mo** Date signed **5-25-40**

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

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.....

P. O. Address.....

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.

X