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JUL 9 1940

Registration District No. **73**

Primary Registration District No. **3006**

Registrar's No. **127**

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

**1. PLACE OF DEATH:**

(a) County Boone

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

(c) Name of hospital or institution: Boone Co Hospl  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 wks 3 days  
In this community life  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** THELMA BURKS 120

**3. (b) If veteran, name war** NO

**3. (c) Social Security No.** NO

**4. Sex** Female

**5. Color or race** White

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

**6. (b) Name of husband or wife** JAMES H BURKS

**6. (c) Age of husband or wife if alive** 26 years

**7. Birth date of deceased** Jan 12th 1921  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>19</u>	<u>5</u>	<u>12</u>	hr. min.

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

**10. Usual occupation** House Wife

**11. Industry or business** " " 0

**12. Name** Virgil Anderson 0

**13. Birthplace** Boone Co MO  
(City, town, or county) (State or foreign country)

**14. Maiden name** Nellie Richardson MAUPIN

**15. Birthplace** Boone Co MO  
(City, town, or county) (State or foreign country)

**16. (a) Informant** James H. Burks

**(b) Address** Huntsdale, MO.

**17. (a) Burial** (b) Date thereof June 15 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Memorial Park Cem.

**18. (a) Signature of funeral director** A. O. Wiggan

**(b) Address**

**19. (a) 6/14/40** (b) Allie Selby  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Boone

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month June day 13th  
year 1940 hour 6 minute 45 A.M.

**21. I hereby certify that I attended the deceased from** May 27  
1940, to June 19, 1940;

that I last saw her alive on June 12, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis with multiple abscesses

Due to perforation of ascending colon

Due to cause unknown

Other conditions Pregnancy 7 months  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: Of operations \_\_\_\_\_

Of autopsy General Peritonitis

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? 14

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

(e) Means of injury \_\_\_\_\_

**23. Signature** James M. Baker (M. D. or other) MD  
Address Columbia, Mo. Date signed June 13th

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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, ~~and~~.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Lynard H. Sprunk

Licensed Embalmer No. 4013

P. O. Address Columbia

**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.**

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Brown  
(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Thelma Burke

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)  
8. AGE: Years 19 Months 5 Days 1 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U.S.A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis with multiple abscesses

Due to perforation of descending colon

Due to cause unknown probably appendiceal abscess

Other conditions sporadic Recurrence at 7 months - 10 days before pregnancy

Major findings pregnancy 10 months

Of operation \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically. 141

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 M. Baker (M. D. or other)

Address Columbia, Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

