

No. 2
13-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30993

State File No. _____

3556

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Kansas City, Mo

(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 2 days (Specify whether
In this community 2 days
years, months or days)

3. (a) PRINT FULL NAME Franklin David Burford

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife none

6. (c) Age of husband or wife if alive none years

7. Birth date of deceased 9 / 9 / 40
(Month) (Day) (Year)

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

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

10. Usual occupation none

11. Industry or business none

MOTHER FATHER

12. Name Frank Peters Burford

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

14. Maiden name Ann Marie Elizabeth

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

16. (a) Informant Father

(b) Address 328 N. Tawm

17. (a) Burial (b) Date thereof 9/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Manfield Ave

18. (a) Signature of funeral director Lee's Summit, Mo.

(b) Address one

19. (a) Sept. 11, 1940 (b) M. M. Kerowe
(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. 328 N. Tawm
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11
year 1940 hour 9 minute 15 P.M.

21. I hereby certify that I attended the deceased from 9/9, 1940, to 9/11, 1940;
that I last saw him alive on 9/11, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute dilatation of heart
irradiated heart disease

Due to _____

Due to _____

Other conditions none 159 C
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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 Walter P. Haworth (M. D. or MD)
Address 1102 Bryant Bldg, N. 5th Date signed 9/11/40

Duration

PHYSICIAN

157c
Underline the cause to which death should be charged statistically.

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, fact should be so stated above.