

Registration District No. **1002**

Primary Registration District No. **1002**

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: **Research Hospital** **0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 Days** (Specify whether
In this community **55 Yrs.** years, months or days)

3. (a) PRINT FULL NAME **Cora Burgard**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **487-10-9231**

4. Sex **Fe.** / 5. Color or race **Wh.** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **Phillip Burgard** 6. (c) Age of husband or wife if alive **1878** years
7. Birth date of deceased **Sept. 3** (Month) (Day) (Year)

8. AGE: Years **62** Months **6** Days **10** If less than one day hr. min.

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

10. Usual occupation **Home**

11. Industry or business

MOTHER FATHER { 12. Name **John McCoy**
13. Birthplace **Urich Mo.** (City, town, or county) (State or foreign country)
14. Maiden name **Sephelia Hisey**
15. Birthplace **Warrensburg Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Clara Martino**
(b) Address **3614 East 18th. K.C. Mo.**

17. (a) **Burial** (b) Date thereof **3-17-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn**

18. (a) Signature of funeral director **Eylar Funeral Home**
(b) Address **1800 Linwood K.C. Mo.**

19. (a) **Mar 15 1941** (b) **Dr. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson** **48**
(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL") **8**
(d) Street No. **3614 East 18th.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar 14** day **14**
year **1941** hour minute M.

21. I hereby certify that I attended the deceased from **Mar. 5** 19**41** to **Mar 14** 19**41**
that I last saw him alive on **Mar 14** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **arteriosclerotic gangrene** **9/5/41**
Due to **left leg**
Due to **Myocarditis**

Other conditions (Include pregnancy within 9 months of death)

Major findings: Of operations

Of autopsy **Yes**

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 **Dr. M. Brown** (M. D. or other)
Address **North Kansas City** Date signed

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.....

Chas Wilks

Licensed Embalmer No.....

2644

P. O. Address.....

1800 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, fact should be so stated above.