

No. 2  
4-4-41  
17-39  
1942

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

17743

State File No. \_\_\_\_\_

FILED JUN 8 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 5276A

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town North Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: R.R. # 8 North K.C. Mo. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 12 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24  
(c) City or town North Kansas City 60  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.R. # 8 0  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MICHAEL LOUIS BURKE

3. (b) If veteran, name war World War #1 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Sena Burke 6. (c) Age of husband or wife if alive 42 years  
7. Birth date of deceased August 12 1896  
(Month) (Day) (Year)

8. AGE: Years 45 Months 9 Days 14 If less than one day .hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Craig, Mo. (City, town, or county) (State or foreign country) 0

10. Usual occupation Carpenter

11. Industry or business

12. Name Michael Burke  
13. Birthplace Missouri (City, town, or county) (State or foreign country) 0  
14. Maiden name Edith Redman  
15. Birthplace Missouri (City, town, or county) (State or foreign country) 0

16. (a) Informant Mrs. Sena Burke

(b) Address R.R. # 8 North K.C. Mo.

17. (a) Burial (b) Date thereof 5/28/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jayman, Mo.

18. (a) Signature of funeral director John S. Morton

(b) Address North Kansas City, Mo.

19. (a) May 26-42 (b) Paul H. Henry  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24  
year 1942 hour 2:00 minute A M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to May 26, 1942.

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage Location at home

Due to Coroner

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations Coroner

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

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) Pulmonary Hemorrhage

(b) Date of occurrence May 26 1942

(c) Where did injury occur? R.R. # 8 North K.C. Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury Coroner

23. Signature P. W. Busher (M. D. or other) Coroner

Address Spears Springs, Mo. Date signed 5-26-42

1021

(Licensed Embalmer's Statement on Reverse Side)

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

JUN 8 1942

2114 Fayette

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

*Olson E. Hodges*

Licensed Embalmer No.....

*2729*

P. O. Address.....

*8329 Union Road North, V.C.*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 17743

Registration District No. 197

Primary Registration District No. 5276A

Registrar's No.

1. PLACE OF DEATH: *Clay*  
 (a) County *Clay*  
 (b) City or town *R.R.*  
 (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 *Michael L. Burke*  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *N*  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased *Aug 12 1897*  
 (Month) (Day) (Year)

8. AGE: Years *45* Months *9* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

11. Industry of 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 \_\_\_\_\_  
 (Burial, cremation, or removal) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month *May* Day *26*  
 year *1942* hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_  
 to \_\_\_\_\_, 19\_\_\_\_  
 that I have examined the body on \_\_\_\_\_, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

*Pulmonary hemorrhage*  
 Due to \_\_\_\_\_  
*Tubercular*  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_ *136'*

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?  
*at home in bed*  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature *P.W. Prother* (M. D. or other) \_\_\_\_\_  
 Address *Exelmar Springs Mo.* Date signed *7-15-42*

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

