

7. S. No. 2
M-9-4-41
5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10511

State File No. _____

FILED APR 12 1943

Registration District No. 7333

Primary Registration District No. 3127

Registrar's No. 24

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

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution:
601 N. Roane St. 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 43 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. 601 N. Roane St
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JAMES R. BURKE

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased JUNE 9 1860
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>8</u>	<u>13</u>	_____ hr. _____ min.

9. Birthplace COOK COUNTY TEXAS 1
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business FARM

12. Name SAMUEL R BURK

13. Birthplace NO DATA 9
(City, town, or county) (State or foreign country)

14. Maiden name SARA FARRIS

15. Birthplace NO DATA 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Geo Hardman

(b) Address Webb City Mo

17. (a) Burial (b) Date thereof 3/14/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Republic, Mo

18. (a) Signature of funeral director HEDDE-NELSON

(b) Address Webb City Mo

19. (a) Mar. 13, 1943 (b) Spradellia Laga
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 12
year 1943 hour 3:07 minute _____ P. M.

21. I hereby certify that I attended the deceased from 20th
15 11, 1941, to March 12, 1943
that I last saw him alive on March 11, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Nephritis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1318

Major findings:
Of operations _____

Of autopsy _____

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 Geo Sam (M. D. or other)
Address Webb City Mo Date signed March 12

Duration _____

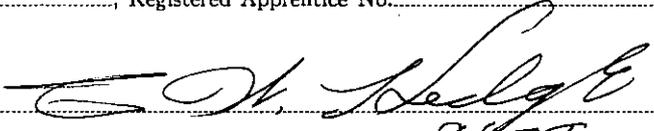
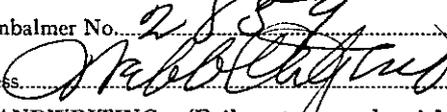
PHYSICIAN _____

Underline the cause to which death should be charged statistically.

43-2-332

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..... 2859
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.