S. No. 2
M—2-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 17 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28959

Registration District No. 347 Primary Registration District No. 6171 Registrar's No.

1. PLACE OF DEATH:

(a) County STONE

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

(c) Name of hospital or institution: R.F.D. 2 / Ponce De Leon
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community MOST OF LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 104

(a) State MO (b) County STONE

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

(d) Street No. R-2.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME GOLDIE BURK

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FE.

5. Color or race W.

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

6. (b) Name of ~~husband~~ or wife J.A. BURK

6. (c) Age of husband ~~or wife~~ if alive 50 years

7. Birth date of deceased AUG (Month) 3 (Day) 1894 (Year)

8. AGE: Years 49 Months 10 Days 16 If less than one day ..... hr. ..... min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business — —

FATHER
12. Name JACK DANIEL
13. Birthplace DO NOT (City, town, or county) KNOW (State or foreign country)

MOTHER
14. Maiden name BETTY ASH
15. Birthplace DO NOT (City, town, or county) KNOW (State or foreign country)

16. (a) Informant J.A. BURK.

(b) Address GALENA MO. R-2

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6/23/44 (Month) (Day) (Year)

(c) Place: burial or cremation PONCE DELON

18. (a) Signature of funeral director KOON FUNERAL HOME

(b) Address CASSVILLE MO

19. (a) July 30/44 (Date received local registrar) (b) Nellie Tromley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19th year 1944 hour 1 minute 20 a M.

21. I hereby certify that I attended the deceased ~~from~~ at death June 19, 1944, to ....., 19....; that I last saw her ~~alive~~ on June 19, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Dropsey of the Cardiac also Tumor of Stomach

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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)

(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?
(Specify type of place)

While at work? (e) Means of injury 3

23. Signature Everett J. Cheatham Coroner (M. D. or other)

Address Galena, Mo. Date signed 6/19/44

1172

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 844-923
Date Filed AUG 15 1944

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 C. M. Jones

Licensed Embalmer No. 3453

P. O. Address Cassville Mo.

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.