S. No. 2
M—5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34185

FILED OCT 23 1945

Registration District No. ____ Primary Registration District No. 3043 Registrar's No. 288

64
3
4
Standardly

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

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Levering Hospital O
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Marion 64
(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2044 Kingshighway 4
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No) 0
If yes, name country ____

3. (a) PRINT FULL NAME Leroy Edward Burch
3. (b) If veteran, name war ____
3. (c) Social Security No. 470-07-4429
4. Sex Male O
5. Color or race White
6. (a) Single, widowed, married, divorced Married /
6. (b) Name of husband or wife Carrie M. Burch
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased August 23, 1881 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
64	1	23	hr. ____ min.

9. Birthplace Virden Illinois / (City, town, or county) (State or foreign country)
10. Usual occupation Shoe Worker
11. Industry or business International Shoe Company
FATHER
12. Name Charles Henry Burch
13. Birthplace Virden Illinois / (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Nellie Proudfit
15. Birthplace Pennsylvania / (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Leroy Burch
(b) Address 2044 Kingshighway Hannibal Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/45 (Month) (Day) (Year)
(c) Place: burial or cremation Mount Olivet
18. (a) Signature of funeral director Crawford Smith
(b) Address 902 Broadway Hannibal Missouri
19. (a) Oct 5 '45 (Date received local registrar) (b) Dr E M Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1 year 1945 hour 9 minute 20 A. M.
21. I hereby certify that I attended the deceased from 10-1, 1945 to 10-1, 1945 that I last saw him alive on 10-1-45, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	20 min
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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) no
(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 ____
23. Signature D Handeeth MD (M. D. or other)
Address Hannibal Mo Date signed 10-2-45

1394

(Licensed Embalmer's Statement on Reverse Side)

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 Crawford Smith

Licensed Embalmer No. 3814

P. O. Address Hannibal Missouri

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.