. S. No. 2
DM—5-42
v. 5-17-39
I X32872

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 15 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41177

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 1044

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town RURAL, S. CAMPBELL TWP
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: OZARK OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 DAYS (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County WEBSTER

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

(d) Street No. 1 mi. NORTH OF FORDLAND
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME LAURA EMELINE BURKS

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife ANDERSON FENTON BURKS

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased DEC (Month) 18, (Day) 1881 (Year)

8. AGE: Years	Months	Days	If less than one day
64	0	0	..... hr. ..... min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business .....

FATHER
12. Name GEORGE LEA
13. Birthplace WEBSTER COUNTY (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name ELIZABETH SHARROW
15. Birthplace WEBSTER (City, town, or county) Mo. (State or foreign country)

16. (a) Informant OLIVE LITTY

(b) Address FORDLAND, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-21-45 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ FORDLAND

18. (a) Signature of funeral director Kelly Funeral Home

(b) Address Fordland Mo

19. (a) 12-18-45 (Date received local registrar) (b) N. H. Hardy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 18 year 1945 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from 12-13, 1945, to 12-18, 1945; that I last saw HER alive on 12-18, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: TULAREMIA	48 DAYS
Due to: CAT BITE	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

23. Signature Howard J. Mason (M.D. or other) D.O.

Address 606 E. Sunshine, Springfield Mo. Date signed 12-19-45

764

(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 L. K. Kelley

Licensed Embalmer No. 3334

P. O. Address Seymour

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.

S. No. 2B
SM—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41177

Registration District No. 128 Primary Registration District No. 5466 Registrar's No. 1044

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural S. Campbell Twp
(If outside city or town limits, write "RURAL" and name of township)

(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)

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

3. (a) PRINT FULL NAME Laura E. Burks

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 18 (Day) 88 (Year)

8. AGE: Years 64 Months 0 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 68
year 1944 hour minute M.

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

Immediate cause of death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

Mrs. Burks died from Tularemia - source of infection was from the bite of a house cat on her finger 26a