

DEPARTMENT OF COMMERCE.
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2094

State File No. _____

FILED FEB 11 1946

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Week (Specify whether years, months or days)
In this community 25 Years

3. (a) PRINT FULL NAME Johannah Burke

3. (b) If veteran, name was None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 43 years (Month) (Day) (Year)
7. Birth date of deceased April (Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Andrew County Missouri (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

12. Name John Burke
13. Birthplace Unknown Ireland (City, town, or county) (State or foreign country)
14. Maiden name Katherine Lysaght
15. Birthplace Unknown Ireland (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bridget Doyle
(b) Address 809 No. 10th. St.

17. (a) Burial (b) Date thereof Jan. 17, 46 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Conception, Missouri

18. (a) Signature of funeral director Wm. J. Sullivan

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) Jan. 17, 1946 (b) W. J. Sullivan (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph (If outside city or town limits, write "RURAL")
(d) Street No. 809 No. 10th. St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14th year 1946 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from January 7, 1946 to Jan 14, 1946 that I last saw her alive on January 14, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Pulmonary embolism 1 day
Due to fracture of femur 1 wk.
Carcinoma of femur 1 yr.
Due to from carcinoma 7 yrs.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 1946 14

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) accident 131
(b) Date of occurrence 1/14/46 Buchanan
(c) Where did injury occur? on 10th St. St. Joseph (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home

(Specify type of place) fall
While at work? no (e) Means of Injury

23. Signature W. J. Sullivan (M.D. or other) Address Conception, Mo. Date signed 1/17/46

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

Elmer Thomas

Licensed Embalmer No.

2640

P. O. Address

St. Joseph 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.