

S. No. 302  
OM-10-47  
5-17-39  
I 3908

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12467

FILED MAY 7 1948  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1737

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days  
(Specify whether years, months or days)  
In this community 75 yrs.

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3029 Independence  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Robert L. Burgess  
(b) If veteran, name war no  
(c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 20  
year 1948 hour 12 minute 25 A.M.

4. Sex M  
5. Color or race W  
6. (a) Single, widowed, married, divorced Wed  
(b) Name of husband or wife MARTHA G.  
(c) Age of husband or wife if alive years  
7. Birth date of deceased May 15 1870  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 15 1948 to April 20 1948  
that I last saw him alive on April 20 1948  
and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 11 Days 25  
If less than one day hr. min.

Immediate cause of death  
Cerebrovascular accident due to arteriosclerosis

9. Birthplace Tongahoxie Kans.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired Contractor  
11. Industry or business Self

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 1/30

MOTHER FATHER  
12. Name Albert Burgess  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy None  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant MRS. W. L. Perry  
(b) Address 3029 Indep Ave.  
17. (a) Burial (b) Date thereof 4-22-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Elmwood  
18. (a) Signature of funeral director C. H. Blackman & Son Inc.  
(b) Address Kansas City, Mo.  
19. (a) 4-21-48 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury \_\_\_\_\_  
23. Signature Wm W. Hart (M. D. or other) \_\_\_\_\_  
Address Med. Dir. Gen'l Hosp. Date signed 4-20-48

*Dr. Holmgren*

1900 1 27 10 116

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**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 *O. K. McFarland*

Licensed Embalmer No. *4397*

P. O. Address *Kansas City 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.**