

FILED APR 6 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9529
State File No.

0804

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 112

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Pettis</u>	
b. CITY OR TOWN <u>Sedalia</u>	c. LENGTH OF STAY (In this place) <u>Yrs.</u>	c. CITY OR TOWN <u>Sedalia</u>	0804
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1107 W. 3rd</u>		d. STREET ADDRESS (If rural, give location) <u>1107 W. 3rd</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Margaret</u> b. (Middle) <u>Mary</u> c. (Last) <u>Burk</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 23, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Mar. 2, 1886</u>
9. AGE (In years last birthday) <u>65</u>	10. MONTHS <u>0</u>	11. DAYS <u>21</u>	12. HOURS <u>0</u> MIN. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Boale Camp, Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>John F. Smasal</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Marie Hirschneuer</u>	14. NAME OF HUSBAND OR WIFE <u>Otto A. Burk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Otto A. Burk</u> ADDRESS <u>1107 W 3</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Valvular Heart Disease</u> ANTECEDENT CAUSES <u>i. Dyspnea.</u> <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Pneumatism (Arterial)</u> DUE TO (c) <u>Infected gums and teeth</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Poorly nourished</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-22</u> , 19 <u>51</u> , to <u>3-23</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3-23</u> , 19 <u>51</u> , and that death occurred at <u>3:00</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Frank B. Langford MD</u> (Degree or title)	23b. ADDRESS <u>Sedalia, Mo</u>	23c. DATE SIGNED <u>3-24-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3-26-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>
DATE REC'D BY LOCAL REG. <u>3-26-51</u>	REGISTRAR'S SIGNATURE <u>A. F. Campbell</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>M. Laughlin Bros</u> ADDRESS <u>515 So Ohio</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

1961 L
RECEIVED 4-5-51

DISTRICT HEALTH OFFICE No. 3

District File Number

Date Filed 4-5-51

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

..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed KPM Gray

Licensed Embalmer No. 3153

P. O. Address Sedatto

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.