

S. No. 300
v. 10.48

0230

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19841

State File No.

FILED JUL 15 1952

BIRTH NO. _____		REG. DIST. NO. <u>70</u>		PRIMARY REG. DIST. NO. <u>5275</u>		Registrar's No. <u>43</u>	
1. PLACE OF DEATH a. COUNTY <u>Clark</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clark</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Des Moines Twp</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wayland Missouri</u>		0230	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Olin</u> b. (Middle) <u>C.</u> c. (Last) <u>Burke</u>			4. DATE OF DEATH <u>July 8th 1952</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 21st 1881</u>	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Alexandria, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Mela Burke</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Johnson</u>			14. NAME OF HUSBAND OR WIFE <u>Martha R. Burke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mary Burke, Wayland Mo</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>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>332X</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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>1-10</u> , 19 <u>40</u> to <u>7-8</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>7-8</u> , 19 <u>52</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE OF REGISTRAR <u>[Signature]</u>				23b. ADDRESS <u>Wayland Mo</u>		23c. DATE SIGNED	
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE <u>7-9-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Frost Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Wayland Mo</u>	
DATE REC'D BY LOCAL REG. <u>7/12-52</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Wayland Mo</u>	

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

H. F. Kirshen

Licensed Embalmer No.

2611

P. O. Address

Wayland, 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.