

FILED SEP 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29829**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1016**

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

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph | | c. CITY OR TOWN St. Joseph | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) Life | | e. STREET ADDRESS (If rural, give location) 1105 South 16th St. | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: Sunnyslope Nursing Home 11st. Road-3225 South 11 | | | |

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|-------------------------------------|------------------------|------------------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Rose | b. (Middle) Elizabeth | c. (Last) Burke | 4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1954 |
|-------------------------------------|------------------------|------------------------------|------------------------|---|

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|----------------------|-------------------------------|---|--|---|----------------------|--------------------|---------------------|--------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH March 31, 1869 | 9. AGE (In years last birthday) 85 | 10. MONTHS 85 | 11. DAYS 85 | 12. HOURS 85 | 13. MIN. 85 |
|----------------------|-------------------------------|---|--|---|----------------------|--------------------|---------------------|--------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Christopher Toole | 13b. MOTHER'S MAIDEN NAME Mary Kennedy | 14. NAME OF HUSBAND OR WIFE Thomas Burke |
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|--|-------------------------------------|--|--------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME Edw. C. Burke | ADDRESS St. Joseph, Mo. |
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| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 2+ years |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive heart disease DUE TO (c) Essential Hypertension | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral arteriosclerosis | | | |

| | | |
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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 4/3 X | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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|--|--|---|
| 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) |
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| | | |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 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 about **about** **1950**, to **9-18**, 1954, that I last saw the deceased alive on **9-18**, 1954, and that death occurred at **6:15p** m., from the causes and on the dates stated above.

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|--|--|---------------------------------|
| 23a. SIGNATURE Lucian H. Idle (Degree or title) m.D. | 23b. ADDRESS 902 Edmond St. Joseph, Mo. | 23c. DATE SIGNED 9-20-54 |
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|---|--------------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Sept 21, 1954 | 24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | 24d. LOCATION (City, town, or county) (State) St. Joseph, Mo. |
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| DATE REC'D BY LOCAL REG. Sept 22, 1954 | REGISTRAR'S SIGNATURE Kathleen M. Allison | 485 | 25. FUNERAL DIRECTOR'S SIGNATURE Herman W. Hedenfaden | ADDRESS 1802 Union St. St. Joseph, Mo. |
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STATEMENT BY LICENSED EMBALMER

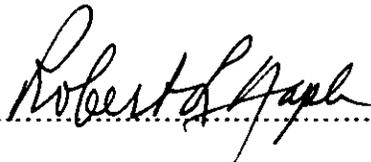
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

by me, or by, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....



Licensed Embalmer No...3308

P. O. Address...St. Joseph,

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.