

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30346

FILED SEP 26 1955

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 249

1. PLACE OF DEATH a. COUNTY RETTIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY COOPER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SEDALIA		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL - CLEAR CREEK 0271	
d. FULL NAME OF HOSPITAL OR INSTITUTION BOTHWELL HOSPITAL		d. STREET ADDRESS (If rural, give location) 1 mi. WEST & 3 mi. NORTH OF CLIFTON CITY, MO	

3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) Joseph c. (Last) Burke			4. DATE OF DEATH (Month) (Day) (Year) 9-20-55		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIAGE HISTORY (Specify) NEVER MARRIED, DIVORCED	8. DATE OF BIRTH SEP. 8, 1895		9. AGE (In years last birthday) 70 If UNDER 1 YEAR: Months _____ Days _____ If UNDER 2 HRS.: Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD		11. BIRTHPLACE (State or foreign country) CLIFTON CITY, MISSOURI	
13a. FATHER'S NAME ROBERT BURKE			13b. MOTHER'S MAIDEN NAME ELLEN SWEENEY		14. NAME OF HUSBAND OR WIFE MATTIE BURKE

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. 710-05-5831		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. ROY ARNOLD TIPTON, 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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage DUE TO (b) Arteriosclerosis E-V disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 443X			

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 **Nov 17, 1955** to **Sept 17, 1955**, that I last saw the deceased alive on **Sept 10, 1955**, and that death occurred at **3:24 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title)		23b. ADDRESS Smithton MO		23c. DATE SIGNED 9/24/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-22-55		24c. NAME OF CEMETERY OR CREMATORY Calvary	
		24d. LOCATION (City, town, or county) Sedalia		(State)	

DATE REC'D BY LOCAL REG. 9-22-55		REGISTRAR'S SIGNATURE Lavinia Cross Deputy		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin Bros Sedalia	
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(Licensed Embalmers' Statement on Reverse Side)

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

OCT 26 1955

NOV 28 1955

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

James R. Asbren

Licensed Embalmer No. *4930*

P. O. Address

Sedalia, 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.