

FILED JAN 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41376**  
Registrar's No. **5678**

|  |  |  |  |   |   |   |   |  |  |
|--|--|--|--|---|---|---|---|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>149</u>  |  | PRIMARY REG. DIST. NO. <u>1002</u>  |   | Registrar's No. _____   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution residence, before admission)<br>a. STATE <b>Missouri</b>   |   |   |   | b. COUNTY <b>Jackson</b>   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>  |  | c. LENGTH OF STAY (in this place) <b>2 wks.</b>  |  | c. CITY OR TOWN <b>Brookfield</b>   |   | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>  |  |  |  | * STREET ADDRESS (If rural, give location) <b>420 East Sedgwick</b>   |   |   |   | <b>0581</b>  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>JOHN</b>  |  |  | b. (Middle) <b>ERNEST</b>                      |   |   | c. (Last) <b>BURCH</b>  |   |  |  |
| 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Dec. 29, 1956</b>  |  |  |  |   |   |   |   |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>   |   | 8. DATE OF BIRTH <b>Nov. 8, 1884</b>  |   | 9. AGE (In years last birthday) <b>72</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Postmaster</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>US Post Office</b>  |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Linn Co. Missouri</b>   |   |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |  |  |
| 13a. FATHER'S NAME <b>James Burch</b>  |  |  | 13b. MOTHER'S MAIDEN NAME <b>Sarah Prather</b> |   |   | 14. NAME OF HUSBAND OR WIFE <b>Caroline Burch</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>None</b>                            |  | 17. INFORMANT'S SIGNATURE OR NAME <b>John S. Burch Dickinson, Texas</b>   |   |   |   | ADDRESS  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Brachopneumonitis</b>  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
|  |  |  |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Congestive Heart Failure</b><br>DUE TO (c) <b>Generalized Arteriosclerosis</b> |   |   |   | <b>4500</b>  |  |
|  |  |  |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Hepato-splenomegaly</b>  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |  |   |   |   |   | 20. AUTOPSY? YES <input checked="" 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) (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 <u>Dec 11, 1956</u> , to <u>Dec 29, 1956</u> , that I last saw the deceased alive on <u>Dec 29, 1956</u> and that death occurred at <u>4:10 pm.</u> , from the causes and on the date stated above. |  |  |  |   |   |   |   |  |  |
| 23a. SIGNATURE (Degree or title) <b>Robert K. Skillingman M.D.</b>   |  |  |  | 23b. ADDRESS <b>4635 Wyandotte, Kansas City, Mo.</b>  |   |   | 23c. DATE SIGNED <b>12-30-56</b>        |  |  |
| 24a. BURIAL CREMATION/REMOVAL (Specify) <b>Burial</b>  |  | 24b. DATE <b>1/2/57</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>  |   | 24d. LOCATION (City, town, or county) (State) <b>Brookfield, Missouri</b>   |   |  |  |
| DATE REC'D BY LOCAL REG. <b>12-31-56</b>   |  | REGISTRAR'S SIGNATURE <b>Wva Marshall</b>  |  |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Hill Funeral Home Brookfield, Mo.</b> |   |   |  |  |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Robert K. Skillingman

1961 4 14 11:45

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.....  
*Richard A. Kepley*

Licensed Embalmer No. 4325

P. O. Address. Indep. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.