Health, & Welfare Public Service
410
S. 300
1-57

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001084
STATE FILE NUMBER

FILED FEB 9 1959 Registration District No. 133 Primary Registration District No. _____ Registrar's No. 11

1. PLACE OF DEATH a. COUNTY: HARRISON	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Mo b. COUNTY: HARRISON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Gilman City — Inside Limits Yes ☑ No ☐	c. CITY OR TOWN: Gilman City — Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Home — Length of stay in lb: 30 YRs	d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First Gaylord Middle MARVIN Last Burke

4. DATE OF DEATH: Month 1 Day 27 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-13-1894

9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months 5 Days 14 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BARBER

10b. KIND OF BUSINESS OR INDUSTRY: BARBER

11. BIRTHPLACE (City and state or country): Nodaway Co

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: John J. Burke

13b. MOTHER'S MAIDEN NAME: Emalie A. Downey

14. NAME OF HUSBAND OR WIFE: Ruth Burke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 500-36-1116

17. INFORMANT: Ruth Burke — Address: Gilman City Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Pericarditis - Myocarditis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____

DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arrested Tuberculosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Jan 20-59, to Jan 27-59 and last saw ~~her~~ him alive on Jan 27-59.
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. B. Bailey DO

22b. ADDRESS: Jamesport Mo

22c. DATE SIGNED: 1-28-59

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)

23b. DATE: 1-29-58

23c. NAME OF CEMETERY OR CREMATORY: Masonic

23d. LOCATION (City, town, or county) (State): Gilman City Mo.

24. FUNERAL DIRECTOR: M B Haas — ADDRESS: Bethany Mo

25. DATE RECD. BY LOCAL REG.: 2-1-1959

26. REGISTRAR'S SIGNATURE: Ofella Maxey

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MAR 5 1959

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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 embalm

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

working under my personal supervision.

Student ..... Signed M B Haas .....

Signature of Student Embalmer

Licensed Embalmer No. 3899

P. O. Address Bethany, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failu 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.