

Health,
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017633
STATE FILE NUMBER

FILED MAY 29 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2238

1. PLACE OF DEATH a. COUNTY <u>JACKSON JACKSON</u>		2. USUAL RESIDENCE OF DECEASED LIVED. If institution: Residence before admission a. STATE <u>KANSAS Missouri</u> b. COUNTY <u>JACKSON JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MEADOW LAKE Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Menorah Medical Center</u> Length of stay in lb <u>1 hour</u>		d. STREET ADDRESS (If outside, give location) <u>2210 W. 77th,</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>T.</u> Last <u>Burleigh</u>			4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-06 1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASST. DIST. MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHRYSLER CORP.</u>	11. BIRTHPLACE (City and state or country) <u>LINCOLN NEB.</u>
13a. FATHER'S NAME <u>J. R. BURLEIGH</u>		13b. MOTHER'S MAIDEN NAME <u>NORA TUMBERG</u>	14. NAME OF HUSBAND OR WIFE <u>MAXINE BURLEIGH</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown, give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO. <u>387 07 0907</u>	17. INFORMANT <u>BURLEIGH</u> Address <u>MAXINE BURLEIGH 2210 WEST 77th STREET</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage - acute -</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Hypertensive cardiovascular disease.</u> <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Healed cerebral myocardial infarct. 4201</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
20e. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
21. I attended the deceased from <u>Jun 10 1957 - May 3 1959</u> and last saw him alive on <u>May 3 1959</u> . 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) <u>Graham Asher M.D.</u>		22b. ADDRESS <u>1270 Professional Kansas City 6. mo. Bldg.</u>	
22c. DATE SIGNED <u>5-4-1959</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 6, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAH</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>D W Newcomer, Son N.E. MO</u>		25. DATE RECD. BY LOCAL REG. <u>5-5-59</u>	26. REGISTRAR'S SIGNATURE <u>neva minahall</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Graham Asher



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

Albert H. Savage

Licensed Embalmer No. 4812

P. O. Address Geneva City

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.