

FILED VS JUL 27 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-025026

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3194

STATE FILE NUMBER

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. MARY'S HOSP.</b>		Length of stay in lb <b>60 YRS.</b>	d. STREET ADDRESS (If outside, give location) <b>4348 ROCKHILL RD.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARA SMITH BURKE</b>			4. DATE OF DEATH Month Day Year <b>JUNE 29 1959</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2- DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 18, 1883</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>ORRICK, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>THOMAS B. SMITH</b>		13b. MOTHER'S MAIDEN NAME <b>MARTHA TOMKINS</b>		14. NAME OF HUSBAND OR WIFE <b>WALTER M. BURKE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>486 09 2707</b>	17. INFORMANT Address <b>MRS. MARY A FASENMYER 4348 ROCKHILL RD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED THORACIC ANEURYSM</b>					INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROSIS</b>					
DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>BILATERAL POLYCYSTIC KIDNEYS</b>					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. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>1 8 58</u> to <u>6 29 59</u> and last saw her alive on <u>6 29 59</u> Death occurred at <u>6 29 59 1:35 P. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Name or title) <i>Mary A Fassenmyer</i>			22b. ADDRESS <b>1420 SO 42nd. St. K. C. K.</b>		22c. DATE SIGNED <b>6 30 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>JULY 1, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MACPELAH CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>LEXINGTON MISSOURI</b>
24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS-KANSAS CITY, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>6-30-59</b>	26. REGISTRAR'S SIGNATURE <i>Neve Minshall</i>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

E. G. Neighbor

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 *Leman W. Lawson* .....

Licensed Embalmer No. *4889* .....

P. O. Address *N.C., Fla.* .....

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.