

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 9 1960

-60-015189

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2284

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>Shawnee</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>KANSAS CITY</u>		Length of stay in 1b <u>6 DAYS</u>	c. CITY OR TOWN <u>TOPEKA</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>310 E. 10th STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type in print) First <u>William</u> Middle <u>WALTER</u> Last <u>BURKE</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>24</u> Year <u>1960</u>	
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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>APR. 13, 1879</u>	9. AGE (last birthday) <u>81 YRS.</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>SCRANTON KANSAS</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>HOLMES BURKE</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH WOODFIELD</u>	14. NAME OF HUSBAND OR WIFE <u>MYRTLE BURKE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>ERMA WILSON 1819 EAST 67th STREET</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. ENTRY WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs -</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>nephrosclerosis - advanced -</u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma bladder - metastases -</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>None</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year <u>4-17-60</u>
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20d. INJURY OCCURRED WHILE AT WORK <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 <u>TOPEKA</u>	COUNTY <u>JACKSON</u>	STATE <u>KANSAS</u>
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21. I attended the deceased from 4-17-60 to death and last saw her alive on 4-24-60
Death occurred at 12:25 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u>	22b. ADDRESS <u>1010 E. W. MEDICAL BLDG. 1ST FLOOR</u>	22c. DATE SIGNED <u>4-24-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>4-24-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PRAIRIE VILLAGE, KANSAS HIGHLAND CEM</u>	23d. LOCATION (City, town, or county) (State) <u>SCRANTON KANSAS</u>
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24. FUNERAL DIRECTOR <u>D. W. NEWCOMER'S SONS KE MO.</u>	ADDRESS <u>[Address]</u>	25. DATE RECD. BY LOCAL REG. <u>4-24-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Logu Fuller
Licensed Embalmer No. 4818
P. O. Address 100 W

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