S. No. 2
1—8-43
5-17-39
X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33130

FILED OCT 22 1945

Registration District No. 4442 Primary Registration District No. 23-80 1000 Registrar's No. 58

1. PLACE OF DEATH:
(a) County Buchanan Co.
(b) City or town St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Meth. Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution life time (Specify whether
In this community ~ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Buchanan 11
(c) City or town St Joseph Mo 1
(If outside city or town limits, write "RURAL")
(d) Street No. 7
(If rural, give location)
(e) Citizen of foreign country? no 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Gerald Emory Birt.
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 7 (Month) 22 (Day) 45 (Year)

8. AGE: Years | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace St Joseph Mo 0 (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name Emory Birt.
13. Birthplace DeKalb Co 0 (City, town, or county) (State or foreign country)
14. Maiden name Nadine Kinlaw.
15. Birthplace Savannah mo 0 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Chas Birt
(b) Address Clarkedale
17. (a) (Burial, cremation, or removal) (b) Date thereof 7 23 45 (Month) (Day) (Year)
(c) Place: burial or cremation Clarkedale Mo
18. (a) Signature of funeral director John Brann
(b) Address Maryville Mo
19. (a) Aug 8-1945 (Date received local registrar) (b) John Clarke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 22, year 1945 hour 9:40 minute P M.
21. I hereby certify that I attended the deceased from 4-30, 1945, to, 19; that I last saw h[illegible] alive on 7-22- 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hydrocephalus	2 mo 22 d
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. A. Kearby (M. D. or other)
Address St Joseph Mo Date signed 7-23-45

1428 (Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed John Brown

Licensed Embalmer No. 3933

P. O. Address Waynesville, 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 this body is not embalmed, fact should be so stated above.

No. 2B
25M—3-45
1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9107

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 8 Local Reg. No. 1138

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Methodist Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo. 22 da. (Specify whether years, months or days)
In this community 2 mo. 22 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. Mo Methodist Hosp. (Parents home at Clarkdale)
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Gerald Emory Burt
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 30 1945 (Month) (Day) (Year)

8. AGE: Years 0 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name Emory Burt
13. Birthplace DeKalb Co (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Nadine Kinder
15. Birthplace Lawrence, Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Char Burt
(b) Address Clarkdale
17. (a) (Burial, cremation, or removal) (b) Date thereof 7-23-45 (Month) (Day) (Year)
(c) Place: burial or cremation Clarkdale, Mo
18. (a) Signature of funeral director Josh Braun
(b) Address Maryville Mo
19. (a) Oct. 24, 1945 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 22 year 1945 hour 9 minute M.
21. I hereby certify that I attended the deceased from April 30 1945 to July 22 1945; that I last saw h alive on July 22 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hydrocephalus	life
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. D. Kearby H. A. Kearby (M. D. or other) MD
Address St Joseph Mo Date signed 7-23-45

SUPPLEMENTARY

33130