MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
39724

85

1. PLACE OF DEATH
County Buchanan. Registration District No.
Township Primary Registration District No. 1001
City St. Joseph (No. 1105 South 16 St. St. Ward)

File No.
Registered No. 1402

2. FULL NAME Thomas Burke
(a) Residence. No. 1105 South 16 Street St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rose E Burke

6. DATE OF BIRTH (MONTH, DAY AND YEAR) February 28, 1829

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	65	9	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Policeman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer City of St Joseph

9. BIRTHPLACE (CITY OR TOWN) New York City
(STATE OR COUNTRY) New York

PARENTS
10. NAME OF FATHER Edward Burke
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Margaret O'Hearne
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Ireland

14. INFORMANT Mrs. Rose Burke
(Address) 1105 South 16 St--St Joseph Mo

15. FILED DEC 9 1929 John G. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 9 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1928 to Dec. 9, 1929 that I last saw him alive on Nov. 10, 1929, and that death occurred, on the date stated above, at 8 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Sclerosis - (Angina pectoris) with occlusion of Coronary artery - (duration) 2 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Arterio Sclerosis general - Hypertension - (duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? History & Physical exam
(Signed) [illegible], M. D.
Dec. 9 19 29 (Address) St Joseph Mo

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Dec. 11 1929
20. UNDERTAKER H. O. Sidenfaden	ADDRESS 1802 Union St.

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Buchanan — Registration District No. 85 — File No. .....

Township ..... — Primary Registration District No. 1001 — Registered No. 1402

City St Joseph (No. ....., ... St. ..... Ward)

2. FULL NAME Thomas Burke

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 28 1864

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
65	9	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 12/4 1929 John G. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 9 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY

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