

DEC 19 1938

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

Dr. Burk
39142
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 316
 (b) Township _____ Primary Registration District No. 2001 Registered No. 821
 (c) City Springfield, Mo. Street No. City Hospital St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1960 N Washington St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec, 23, 1925

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
13 8 10

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Student
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

FATHER 13. NAME Noah Sheburn

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Christian Lake

MOTHER 15. MAIDEN NAME Clara Stone

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greene Co. Mo

17. INFORMANT (ADDRESS) Mr. Noah Sheburn Springfield, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Valley DATE Nov 5, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alma J. Sawyer Springfield, Mo

20. FILED Nov 4, 1938 Chas. A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 3, 1938

22. I HEREBY CERTIFY That I attended deceased from June 30, 1938 to Nov 3, 1938
 Last saw her alive on Nov 3, 1938 Death is said to have occurred on the date stated above, at 7:35 P.M.

The principal cause of death and related causes of importance were as follows:

Endocarditis (following Gonorrhea)
Paratyphoid fever
Chronic hepatitis

Date of onset

Other contributory causes of importance:

Name of operation None Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Dr. Burk M. D.
 (Address) Springfield, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.