DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

39768

State File No. Nov. 16-1939

DEC 15

Registration District No. 349 — Primary Registration District No. 1-487 — Registrar's No. 349

1. PLACE OF DEATH:

(a) County Henry — (b) City or town Tebo Twp. 2
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution — In this community 5 months. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo — (b) County Henry.

(c) City or town R. F. D. 2. Calhoun.
(If outside city or town limits, write "RURAL")

(d) Street No. — (If rural, give location)

(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Everett Allen Burk.

3. (b) If veteran, name war — 3. (c) Social Security No.

4. Sex Male — 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 May (Month) 24 (Day) 1929 (Year)

8. AGE: Years 10 — Months 5 — Days 19 — If less than one day hr. — min.

9. Birthplace Delhi (City, town, or county) New York (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Ralph T. Burk
13. Birthplace Ekley (City, town, or county) Okla (State or foreign country)

MOTHER
14. Maiden name Vida Hotchkiss
15. Birthplace New York City (City, town, or county) N. Y. (State or foreign country)

16. (a) Informant's own signature Ralph T. Burk
(b) Address Calhoun Mo. R.F.D. 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov - 18 - 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Pisgah.

18. (a) Signature of funeral director Sweeney-Phillips
(b) Address Warrensburg Mo. R.F.D.

19. (a) Nov. 18-1939 (Date received local registrar) (b) Mrs. Edith E. Simpson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17th year 1939 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from Nov. 15, 1939, to Nov. 17, 1939, that I last saw him alive on Nov. 16, 1939, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Meningitis	7 days
Due to	
Due to	
Other conditions (Includes 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 Hany Harkness (M. D. or other) Date signed 11/17/39
Address 217½ N. Holden Warrensburg. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 7
District File Number 7-39-1638
Date Filed 12-8-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ~~embalmed~~ not Embalmed. by me, or by.....

R. Q. Phillips, Registered Apprentice No.....

working under my personal supervision.

Signed R. Q. Phillips

Licensed Embalmer No. 2320

P. O. Address Warrensburg, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

39768
Do not use this space.

1. PLACE OF DEATH
(a) County Henry — Registration District No. 349
(b) Township Leeo — Primary Registration District No. 5489 — Registered No.
(c) City — (d) Street No. — (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 Everett Allen Burke.
(a) Residence, No. — 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	S

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	10	5	19	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE ,19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ,19 Local Registrar.

SUPPLEMENTARY

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 17 ,1939

22. I HEREBY CERTIFY, That I attended deceased from ,19 , to ,19
I last saw h alive on ,19 Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Meningitis	
(Meningococcus Type Lewis.)	
Other contributory causes of importance:	

Name of operation 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?
If so, specify
(Signed) Harry Harkness, M. D.
(Address) Warrensburg, Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
1. 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.