

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

JAN 10 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42596

Registration District No. 4

Primary Registration District No. 3001

Registrar's No. 312

1. PLACE OF DEATH:
 (a) County Louisiana
 (b) City or town Kirkville, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
815 N. Davis St.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community 45 years
 years, months or days

8. (a) PRINT FULL NAME Louis John Burk
 8. (b) If veteran, name war ✓
 8. (c) Social Security No. ✓

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Bessie Burk
 6. (c) Age of husband or wife if alive 58 years
 7. Birth date of deceased March 18 1872
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 9 7 hr. min.

9. Birthplace Warsaw, Ill. Ill.
 (City, town, or county) (State or foreign country)

10. Usual occupation Butcher

11. Industry or business Meat & Packing

MOTHER FATHER
 12. Name Peter Burk
 13. Birthplace Darmstadt Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Katherine Smith
 15. Birthplace unknown Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bessie Burk
 (b) Address 815 N. Davis

17. (a) Highland Park (b) Date thereof Dec. 27, 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park

18. (a) Signature of funeral director Davis Funeral Home
 (b) Address Kirkville, Missouri

19. (a) 12-27-39 (b) Spencer L. Freeman
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County _____
 (c) City or town _____
 (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.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec 25 day 25
 year 1939 hour 6 minute 15 M.
 21. I hereby certify that I attended the deceased from Dec 20
1939 to Dec 23, 1939
 that I last saw him alive on Dec 23, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy
 Due to Coronary heart disease

Other conditions g.i.t.
 (Include pregnancy within 3 months of death)

Major findings: ✓
 Of operations _____
 Of autopsy ✓

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) no
 (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?
at

While at work? ✓ (Specify type of place) (e) Means of injury _____

23. Signature L. J. Cannon (M. D. or other) _____
 Address Kirkville, Mo. Date signed _____

Duration
 Physician
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 1-40-82

Date Filed JAN 3 1940

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 Harold A. Kigal
Licensed Embalmer No. 4076
P. O. Address Tricksville, W.

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.