

FILED MAR 5 - 1940

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

7812

Do not use this space.

1. PLACE OF DEATH *Platte* *0* Registration District No. *695*
 (a) County *Platte* *0* Township *Pettis* Primary Registration District No. *5922* Registered No. _____
 (c) City *Northern Heights* (d) Street No. _____ 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 *Wanda Lee Burks*
 (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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Oct 2 - 1937</i>		
7. AGE	YEARS <i>2</i>	MONTHS <i>5</i>
	DAYS <i>18</i>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <i>Child</i>	
	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) <i>Northern Heights Parkville Mo 0</i>		
FATHER	13. NAME <i>Ralph A. Burks 0</i>	
	14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) <i>Jacksonport Missouri 0</i>	
MOTHER	15. MAIDEN NAME <i>Addie Lee Siders</i>	
	16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) <i>K.C. Mo</i>	
17. INFORMANT <i>Ralph A. Burks</i> (ADDRESS) <i>R.F.D. #3 Parkville Mo</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Herman Cem</i> DATE <i>Feb. 22 80</i>		
19. FUNERAL DIRECTOR (NAME) <i>Leland H. Francis</i> (ADDRESS) <i>Parkville Mo</i>		
20. FILED <i>3-1</i> 19 <i>40</i> <i>S.P. Ford</i> Local Registrar		

Dr. Pate (M.D.) CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2/20*, 19*40*

22. I HEREBY CERTIFY, That I attended deceased from *2/19*, 19*40*, to *2/20*, 19*40*.
 I last saw him alive on *2/19*, 19*40*. 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:
Bacterial Pneumonia
 Date of onset *10 7 40*

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis *Smear* Was there an autopsy? *no*

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. Pate* _____, M. D.
 (Address) *North Kansas City, Mo*

Licensed Embalmer's Statement on Reverse Side)

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

PLACE OF DEATH

(a) County
(b) Town

RECEIVED

District Health Officer No. 11

District File Number 340-206

Date Filed 1940 MAR 4

1937-9-2

MEDICAL CERTIFICATE OF DEATH

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, yes

Signed Leland H. Francis

Licensed Embalmer No. 3451

P. O. Address Parkville 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, above space should be left blank.

Embalmer

RECORDS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7812

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 695-

Primary Registration District No. 5922

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Platte

(b) City or town Pettis - Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME Maude Lee Burks

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 2 Months 5 Days 18 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

{ 13. Birthplace..... (City, town, or county) (State or foreign country)

{ 14. Maiden name.....

{ 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (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.

20. DATE OF DEATH: Month 2 day 20 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that I last saw him..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to.....

Due to.....

Other conditions None (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

Duration

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?.....

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

23. Signature D. S. Pate (M. D. or other) Address 7 Kansas City Date signed mo

SUPPLEMENTARY

