

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

8478
Do not use this space.

1. PLACE OF DEATH

(a) County Wenona Registration District No. 875
 (b) Township Washington Primary Registration District No. 167 Registered No. 33
 or
 (c) City Keosauqua (d) Street No. State Hospital #3 St. Keosauqua
 (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. 620 Thomas C. Burke 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mrs. T.C. Burke</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>9-20-1869</u>		
7. AGE	YEARS	MONTHS
<u>70</u>	<u>7</u>	<u>4</u>
		DAYS
		<u>16</u>
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Laborer in zinc smelter.</u>	
	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)
unknown

FATHER 13. NAME Patrick Burke

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Ireland

MOTHER 15. MAIDEN NAME Mary Corry

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Ireland

17. INFORMANT (ADDRESS)
Hosp. Record

18. BURIAL, CREMATION, OR REMOVAL
PLACE Joplin, Mo. DATE 2/8, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS)
Wenona, Mo.

20. FILED Feb. 7, 1940 Allen W. Hays Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-6, 1940

22. I HEREBY CERTIFY, That I attended deceased from 1-25, 1939, to 2-6, 1940

I last saw him alive on 2-6, 1940. Death is said to have occurred on the date stated above, at 5:15 P.M.
 The principal cause of death and related causes of importance were as follows:

Tobacco pneumonia
type unknown

Other contributory causes of importance:
Chronic Myocarditis

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) A. J. Corry, M. D.
 (Address) State Hosp #3

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Handwritten: 618 of 78 1009

Handwritten checkmark

Handwritten circled 3

Handwritten exclamation point

Handwritten signature: Allen W. Hays

2 No. 18
M-5-31-4
17 X 1 A

RECEIVED
District Health Officer No. 7.
District File Number 3-40-344
Date Filed 3-4-40

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 Marsh L. Lickinger
Licensed Embalmer No. 2656
P. O. Address Nevada, 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.

No 2h
-2-21-40
I X22659

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 8478

Registration District No. 875

Primary Registration District No. 6167

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wernon
(b) City or town Washington
(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 _____ years, months or days)

3. (a) PRIN FULL NAME Thomas C. Burske

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

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

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

7. Birth date of deceased 9 20 18
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 4 16 _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2/9/40 (b) Allen V. Hays
(Date received local registrar) (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 6
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I was saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(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) _____

(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 F. C. Long (M. D. or other) _____

Address State House #3 Nevada Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

