

Registration District No. 736

Primary Registration District No. 4090

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Harrisonville
(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 80 years, months or days) 2

8. (a) PRINT FULL NAME GILFORD DUDLEY BURKE

8. (b) If veteran, name war ✓ 8. (c) Social Security No. NO.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Martha Burke 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased (Month) Nov (Day) 11 (Year) 1860

8. AGE: Years 80 Months 0 Days 2 If less than one day hr. min.

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

10. Usual occupation 0

11. Industry or business 4

12. Name Joseph Burke

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

14. Maiden name Elizabeth Walker

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

16. (a) Informant Mr. Will Linsley

(b) Address Harrisonville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Orion Cemetery

18. (a) Signature of funeral director RUNNENBURGER'S

(b) Address HARRISONVILLE, MO.

19. (a) 11/20/40 (Date received local registrar) (b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Harrisonville
(If outside city or town limits, write "RURAL")
(d) Street No. 1100 N. Lexington
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 18th year 1940 hour 4:55 minute P. M.

21. I hereby certify that I attended the deceased from May 1940, to Nov. 1940

that I last saw him alive on Nov. 15 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Prostatic Carcinoma Duration 14 months

Due to _____

Due to _____ 51

Other conditions Uremia
(Include pregnancy within 3 months of death)

Chronic nephritis

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? 815

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

23. Signature Geo. C. Welch (M.D. or other) 10.0

Address 104 W. Pearl St. Date signed 11/20/40

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Ernest R. Runnburger

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.