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X26390

FILED NOV 13 1941

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Trass**  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **30 yrs. 0** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Jackson** <sup>040</sup>

(c) City or town **Manassas** <sup>365</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. **523 Grand Ave**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Frank Burdick**

3. (b) If veteran, name war **none**

3. (c) Social Security No. **Unknown**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **10** year **1941** hour **4** minute **55 P.** M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ on \_\_\_\_\_ 19\_\_\_\_; and that he died \_\_\_\_\_ on the date and hour stated above. Immediate cause of death \_\_\_\_\_

4. Sex **male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Mable Burdick** 6. (c) Age of husband or wife if alive **58** years

7. Birth date of deceased: **1881**  
(Month) (Day) (Year)

Duration \_\_\_\_\_

Physician **Robert J. [Signature]**

8. AGE: Years **60** Months **-** Days **-** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to **Cerebral hemorrhage**

Other conditions **8:30**  
(Include pregnancy within 3 months of death)

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

10. Usual occupation **Salesman**

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name **Abbert Burdick**

13. Birthplace **New York**  
(City, town, or county) (State or foreign country)

14. Maiden name **Do not know**

15. Birthplace **Do not know**  
(City, town, or county) (State or foreign country)

Major findings: **4:30**  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Rev. Ferguson**

(b) Address **Parkville Mo**

17. (a) **Burial** (b) Date thereof **Oct 12, 1941**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Parkville Mo**

18. (a) Signature of funeral director **Noland Funeral Home**

(b) Address **Parkville Mo**

19. (a) **10/12/41** (b) **M. M. Crowe**  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury

While at work \_\_\_\_\_

23. Signature **[Signature]** (M. D. or other) \_\_\_\_\_

Address **Mo** Date signed \_\_\_\_\_

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

**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 Park Rowe

Licensed Embalmer No. 2347

P. O. Address K C MD

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

**If this body is not embalmed, fact should be so stated above.**