

S. No. 2
M-5-43
v. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5096
Registrar's No. 565

Registration District No. 147 Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospt.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 42 days
(Specify whether years, months or days) 63 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1414 Madison
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Margaret Burke
(b) If veteran, name war XX
(c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 4
year 1945 hour 5-10 minute A M.
21. I hereby certify that I attended the deceased from Crown, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

4. Sex Fe. 5. Color of race W.
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive years

Immediate cause of death Burns - 2nd & 3rd degree (Face-neck-chest)
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

8. AGE: Years Aprox. 63 Months Days If less than one day hr. min.

Major findings: History & Inspection
Of operations
Of autopsy not
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

10. Usual occupation House work
11. Industry or business
12. Name Michael Burke
13. Birthplace Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Flanigan
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident 123
(b) Date of occurrence 12-24-44
(c) Where did injury occur? 1414 Madison, K.C. Jackson, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
about home
While at work? yes (Specify type of place) (e) Means of injury Gas stove
23. Signature James E. Brown (M. D. or other)
Address 1424 1/2 Main St. Date signed 2-5-45

16. (a) Informant Mrs. H. G. Maxwell
(b) Address 2411 Quincy
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/45
(Month) (Day) (Year)
(c) Place: burial or cremation St. Marys Cem.
18. (a) Signature of funeral director H. Tigerman & Sons
(b) Address K. C. Mo.
19. (a) 2-5-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

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.....

J. S. Walton

Licensed Embalmer No.....

2744

P. O. Address.....

R. C. 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, fact should be so stated above.