

FILED APR 23 1945

State File No. 12049

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1613

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: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether)

In this community 65 years
years, months or days

3. (a) PRINT FULL NAME Miss Nellie C. Burke

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female

5. Color or race Wh

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 29, 1879
(Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 10
If less than one day hr. _____ min. _____

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

10. Usual occupation Schoolteacher

11. Industry or business K.C. MO Schools

12. Name Wm. Burke

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

14. Maiden name Margaret Burke

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

16. (a) Informant Miss Agnes Burke

(b) Address 3811 Troost

17. (a) Burial (b) Date thereof 8-11-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Thos. H. Quirk

(b) Address 4316 Troost

19. (a) 4-10-45 (b) Geraldine
(Date received local registrar) (Registrar's signature)

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. 3811 Troost
(If rural, give location)

(e) Citizen of foreign country? 11 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 9 year 45 hour _____ minute 30 AM/PM

21. I hereby certify that I attended the deceased from April 6 to April 9, 1945.
that I last saw her alive on April 9, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Pulmonary Edema

Due to Myocardial failure (heart)

Due to _____

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

Major findings: Of operations 111

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 MI

Signature Max Friedman (M. D. or other) _____
Address 618 Prof. Bldg. Date signed 4-9-45

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

MOTHER FATHER

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.....

working under my personal supervision.

....., Registered Apprentice No.

Signed..... *Thomas J. Zwick*

Licensed Embalmer No. *3775*

P. O. Address..... *J. C. M.*

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.