S. No. 2
M—2-43
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I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 21 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27886

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 225

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 705 Vermont St
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Marion 4
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 705 Vermont St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Eva Burkley
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Fe Male 5
5. Color or race Negro
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Wm Burkley
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 9 (Month) 11 (Day) 1866 (Year)

8. AGE: Years 78 Months 9 Days 12 If less than one day hr. min.

9. Birthplace Ralls Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Ralls Mo
11. Industry or business
FATHER
12. Name Henry Tate
13. Birthplace Rall (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name unknown
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Arch Harris
(b) Address 2002 Settles St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 (Month) 26 (Day) 45 (Year)
(c) Place: burial ~~or cremation~~ Baptist Cem.
18. (a) Signature of funeral director Geo E Roberts
(b) Address Hannibal Mo
19. (a) 8/7/45 (Date received local registrar) (b) Dr E. M. Fucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 23 year 1945 hour 10 minute P.M.
21. I hereby certify that I attended the deceased from Mar 10, 1945 to June 23, 1945 that I last saw her alive on June 23, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Mitral Insufficiency	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 92	
Of autopsy	

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

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)
While at work? (e) Means of injury
23. Signature H. M. Meeker (M.D. or other) M.D.
Address Hannibal Mo Date signed 6/24/45

1394

(Licensed Embalmer's Statement on Reverse Side)

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 Geo. E. Roberts

Licensed Embalmer No. 2113

P. O. Address Hannibal

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.