

FILED MAY 27 1946

Registration District No. **199** Primary Registration District No. **1002**

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:
3819 Warwick Blvd.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **82 years** (Specify whether years, months or days)

In this community _____ years, months or days

3. (a) PRINT FULL NAME **John J. Burke**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **Rose M. Burke**

6. (c) Age of husband or wife if alive **85** years

7. Birth date of deceased **aug 27, 1863**
(Month) (Day) (Year)

8. AGE: Years **82** Months **8** Days **20** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired Employee**

11. Industry or business **K.C. Mo. Park Dept.**

12. Name **William 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 **Mrs. Rose M. Burke**

(b) Address **3819 Warwick Blvd.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **May 20, 1946**
(Month) (Day) (Year)

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

18. (a) Signature of funeral director **Thos. E. Quirk**

(b) Address **4316 Troost Ave.**

19. (a) **5-18-46** (Date received local registrar) (b) **Geraldine Holmes** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No. **3819 Warwick Blvd.**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **17th** year **1946** hour **5** pm minute _____ M.

21. I hereby certify that I attended the deceased from **15 May** 19 **46** to **17th May** 19 **46**

that I last saw him alive on **17 May** 19 **46** and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia**

Duration **3 days**

Due to **nephritis, chronic**
Cause undetermined

Due to **pyelitis, chronic**
cause undetermined

Other conditions **edema & its results**
(Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **none**

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?

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

23. Signature **Albert J. Lippens** (M.D. or other) Address **5845 Prospect** Date signed **17 May 46**

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

15410

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 Thomas E. Zwick

Licensed Embalmer No. R. E. M.

P.O. Address #3775

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.