

S. No. 2
DM-5-43
v. 5-17-39
I X36671

30898

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 6 1947
128

802

Registration District No. _____

Primary Registration District No. 2000

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(c) Name of hospital or institution: **Burge Hospital**
(d) Length of stay: In hospital or institution **3 days**
In this community _____
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Webster**
(c) City or town **Rogersville Route 3**
(d) Street No. **3 1/2 Miles N.E. of Rogersville**
(e) Citizen of foreign country? **no.**
If yes, name country _____

3. (a) PRINT FULL NAME **James Pleasant Burks**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **M** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **Nannie** 6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **Nov 2 1881**
(Month) (Day) (Year)

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

9. Birthplace **Fordland Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Sam Burks**

13. Birthplace **Not known Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Jones**

15. Birthplace **Not known not known**
(City, town, or county) (State or foreign country)

16. (a) Informant **Georgia Glaubitz (daughter)**

(b) Address **Rogersville Route 3**

17. (a) **Burial** (b) Date thereof **Sept 24 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **White Oak Cemetery**

18. (a) Signature of funeral director **Kelly Farrell**

(b) Address **Rogersville Mo.**

19. (a) **9-18-47** (b) **W. S. Handley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **10**
year **1947** hour **2** minute **10** P.M.

21. I hereby certify that I attended the deceased from **Aug 10** 19 **47** to **Sept 10** 19 **47**
that I last saw him alive on **Sept 10** 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis** Duration **1 Mo.**

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

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 _____

23. Signature **Dr. Gene Faithing** (M. D. or other) _____

Address **Holland Bldg, Springfield** Date signed **Sept 12 '47**

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

MOTHER FATHER

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

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 *K. H. Kelley*.....

Licensed Embalmer No. *3334*.....

P. O. Address *Fordland 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.