

No. 2
1/47
17-39

FILED MAY 18 1948
Registration District No. 285

Primary Registration District No. 3011

Registrar's No. 46

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

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Southern Hosp.
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette

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

(d) Street No.
(If rural, give location)

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

3. (a) PRINT FULL NAME JOHN F BURK

3. (b) If veteran, name war.

3. (c) Social Security No.

4. Sex Mo 5. Color W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah C Burk 6. (c) Age of husband or wife if alive 87 years

7. Birth date of deceased Jan 4 1861
(Month) (Day) (Year)

8. AGE: Years 87 Months 3 Days 26
If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

12. Name Dan Burk

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

14. Maiden name Unknown

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

16. (a) Informant Dan W Burk
(b) Address Summerville, Mo

17. (a) Interment (b) Date thereof 5-1-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dover Mo

18. (a) Signature of funeral director F. F. Tempel
(b) Address Lexington Mo

19. (a) 5/1/48 (b) Am. Herbert Colwell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 30 year 1948 hour 6 minute 00 P.M.

21. I hereby certify that I attended the deceased from Apr 27 1948 to Apr 30 1948
that I last saw him alive on Apr 30 1948
and that death occurred on the date and hour stated above.

Immediate cause of death T. rupture of right hip

Due to

Due to

Other conditions Malignant cancer of rt. Cervical Junction Lung
(Include pregnancy within 6 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) 17

(b) Date of occurrence

(c) Where did injury occur?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(e) Means of injury

23. Signature [Signature] (M. D. or other) 17
Address Carrollton, Mo Date signed 5/30/48

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

MOTHER FATHER

ADDITIONAL POST-MORTEM INVESTIGATION REQUESTED

RECEIVED.

District Health Officer No. 8,

District File Number.....

Date Filed 5-17-48.....

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 Ben W. Gibson.....

Licensed Embalmer No. 2961.....

P. O. Address Carrollton, Va.....

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..

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *June*
Registrar's No. *46*

Registration District No. *355* Primary Registration District No. *3011*

1. PLACE OF DEATH:
(a) County *Carroll*
(b) City or town *Austen*
(c) Name of hospital or institution:
(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)
3. (a) PRINT FULL NAME *John F. Bush*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *M*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased *Jan 4* (Month) *4* (Day) _____ (Year)

8. AGE: Years *87* Months *02* Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

MOTHER FATHER
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year *1947* month _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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) *Accident in home*
(b) Date of occurrence *Apr 27*
(c) Where did injury occur? *Fayette Mo.* (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? *home*
While at work? *at work* (Specify type of place) (e) Means of injury *fall*

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

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

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

S-15667