

FILED MAR 9 1955

STANDARD CERTIFICATE OF DEATH

State File No. 4364

BIRTH NO. REG. DIST. NO. 100 PRIMARY REG. DIST. NO. 3018 Registrar's No. 18

331

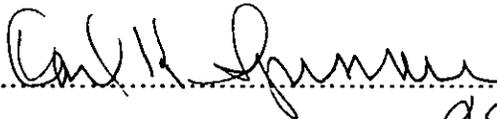
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Dent		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dent	
b. CITY OR TOWN Salem		c. CITY OR TOWN Salem	
c. LENGTH OF STAY (in this place) few months		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION X		e. STREET ADDRESS (If rural, give location) East 3rd 0331 0	
3. NAME OF DECEASED (Type or Print) a. (First) Marie b. (Middle) - c. (Last) Burke		4. DATE OF DEATH (Month) (Day) (Year) 2-24-55	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) --	8. DATE OF BIRTH Aug 8 1904
9. AGE (In years last birthday) 50		10. MONTHS 4	11. DAYS 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY X	
11. BIRTHPLACE (City and State or Foreign Country) Dent Co Mo 0		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME Joseph Burke		13b. MOTHER'S MAIDEN NAME Rosie Rhinberger	
14. NAME OF HUSBAND OR WIFE --			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No X		16. SOCIAL SECURITY NO. X	
17. INFORMANT'S SIGNATURE OR NAME Mrs Lillian Hermes		ADDRESS Salem Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial military tuberculosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized tuberculosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 0192	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 15, 1954, to JAN 15, 1955, that I last saw the deceased alive on JAN 15, 1955, and that death occurred at 9:55 P.M., from the causes and on the date stated above.			
23a. SIGNATURE B. J. Bass M.D. (Degree or title)		23b. ADDRESS Salem, Missouri	
23c. DATE SIGNED 2/25/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 93 2-26-55	
24c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cem		24d. LOCATION (City, town, or county) Salem Mo (State)	
DATE REC'D BY LOCAL REG. 2-26-55		REGISTRAR'S SIGNATURE M. M. Hart, M.D. by one	
25. FUNERAL DIRECTOR'S SIGNATURE G. W. Spencer		ADDRESS Salem Mo	

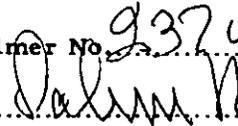
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... 

Licensed Embalmer No. 9376

P. O. Address..... 

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.