

FILED APR 7 1956
RN 10727

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8219
State File No. _____
Registrar's No. 218

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). --a- STATE Missouri b. COUNTY Texas	
b. CITY (If outside corporate limits, write RURAL and give town) Poplar Bluff		c. CITY OR TOWN Arroll	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 76 days		e. STREET ADDRESS (If rural, give location) none	
d. FULL NAME OF HOSPITAL OR INSTITUTION VA Hospital			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) DANIEL	b. (Middle) LOUIS	c. (Last) BURKS	Mar. 18, 1956		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 5/10/96	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saw Mill Operator		10b. KIND OF BUSINESS OR INDUSTRY Lumber	11. BIRTHPLACE (City and State or Foreign Country) Pulaski Co., Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Johnson Burks		13b. MOTHER'S MAIDEN NAME Ellen Decker		14. NAME OF HUSBAND OR WIFE Nora Burks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME VA Hospital Records ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, head of pancreas		DUE TO (b) Generalized carcinomatosis secondary to Dg # 1, involving the liver, gall bladder, mesentery, small bowel,			4 months
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) large bowel & parietal peritoneum			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) VA		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 Jan. 2, 1956, to Mar 18, 1956, and that death occurred at 10:30a., from the causes and on the date stated above.

23a. SIGNATURE Ernest M. Tapp, M.P. - MANAGER (Degree or title)			23b. ADDRESS VAH, Poplar Bluff, Mo.		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal			24c. NAME OF CEMETERY OR CREMATORY Mr. View, Mo.		

24b. DATE 3-19-56		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. 3/23/56		25. FUNERAL DIRECTOR'S SIGNATURE Frank-Cotrell ADDRESS Poplar Bluff, Mo.	

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

RECEIVED

MAR 26 1956

BUTLER CO. HEALTH CENTER

FILE No. _____

MAR 15 1956

MAY 28 1957

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 *George D. Green*

Licensed Embalmer No. 2964

P. O. Address *Springfield*

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.