

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 27 1957

16541  
STATE FILE NUMBER  
77 Primary Registration District No. 3016 Registrar's No. 173

Registration District No. 77

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Registrar's No. 173

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No Name

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms written there. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <b>Cole</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Cole</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jefferson City</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>Jefferson City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp</b>		Length of stay in lb <b>10yrs</b>		d. STREET ADDRESS (If outside, give location) <b>026 1/2 320 Washington St</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William H. Burke</b>				4. DATE OF DEATH Month Day Year <b>May 24 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept-11-1874</b>		9. AGE (In years last birthday) <b>82</b>	F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Revenue Dpt</b>		11. BIRTHPLACE (City and state or country) <b>Rantoul, Ills</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Pharcellus Burke</b>		13b. MOTHER'S MAIDEN NAME <b>Isabelle Moyr</b>		14. NAME OF HUSBAND OR WIFE <b>Rose Burke</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Rose Burke, Jefferson City, Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of prostate gland</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Death occurred at <b>9/14/55</b> to <b>5/24/57</b> and last saw her alive on <b>5/24/57</b> * m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Ernest D. Sugarbaker M.D.</b> (Degree or title)		22b. ADDRESS <b>Jefferson City, Mo</b>		22c. DATE SIGNED <b>5/24/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5/25/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rantoul, Ills</b>		
24. FUNERAL DIRECTOR <b>Thorpe J Gordon</b>		ADDRESS <b>Jefferson City, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>25 May 1957</b>		26. REGISTRAR'S SIGNATURE <b>R.P. Darris, M.D. - T.R.</b>	

STATE OF TEXAS

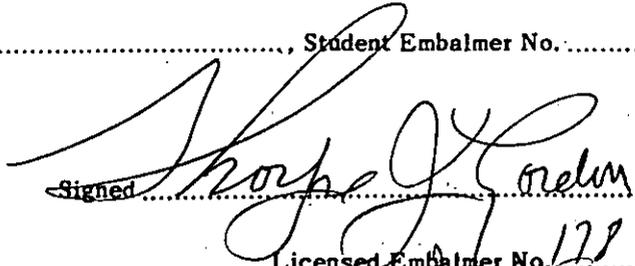
DEPARTMENT OF HEALTH

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. 1286

P. O. Address: J. J. Corbin

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.