

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

58-039726

STATE FILE NUMBER

Health,  
 & Welfare  
 Public  
 Service  
 51

300 4  
 1-57

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 101

**FILED DEC 1 1958**

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fayette, Missouri</b>		c. CITY OR TOWN <b>Fayette</b> <sup>0451</sup> 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>Shields B. Home</b>		d. STREET ADDRESS (If outside, give location) <b>104 N. Linn St.</b>	
Length of stay in 1b <b>2 weeks</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>RICHARD</b> Last <b>BURKE</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>2,</b> Year <b>1958</b>
5. SEX <b>Male</b> <sup>0</sup>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1898</b>
9. AGE (In years last birthday) <b>60</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	11. BIRTHPLACE (City and state or country) <b>Howard County, Mo.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POULTRY House</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Gabriel Connor Burke</b>		13b. MOTHER'S MAIDEN NAME <b>Susie Jane Thornhill</b>	14. NAME OF HUSBAND OR WIFE <b>-----</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. <b>495-07-6330</b>	17. INFORMANT <b>Sally J. Walters</b> Address <b>500 S. Cleveland Fayette, 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>Acute Cardiac decompensation</b> DUE TO (b) <b>Malignancy of prostate &amp; metastasis.</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) _____			INTERVAL BETWEEN ONSET AND DEATH <b>none</b> <b>1 1/2 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		177X	
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 WORK <input type="checkbox"/> NOT WHILE 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>6:30 AM, Jan. 1957</b> to <b>Nov 2-58</b> and last saw her alive on <b>Oct 26-58</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Mary L. Shaw M.D.</b>		22b. ADDRESS <b>Fayette, Mo.</b>	
22c. DATE SIGNED <b>11-4-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/4/1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fayette, Missouri</b>	
24. FUNERAL DIRECTOR <b>Salvador A. Carr</b>		25. DATE RECD. BY LOCAL REG. <b>11-4-58</b>	
ADDRESS <b>Fayette, Mo.</b>		26. REGISTRAR'S SIGNATURE <b>Mary L. Shell</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ralph A. Carr* .....

Licensed Embalmer No. *3340* .....

P. O. Address *Fayette, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.