

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001424

FILED VS FEB 1 1960

270

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. 270

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Bates	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Butler	
Length of stay in 1b 2 Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Hospital		d. STREET ADDRESS (If outside, give location) 104 So Delaware	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First SALLIE Middle ELIZABETH Last BURKETT			4. DATE OF DEATH Month January Day 16 Year 1960			
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1891	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Pettis Co Missouri	11. BIRTHPLACE (City and state or country) USA	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Charles E O'Bannon	13b. MOTHER'S MAIDEN NAME Mary M Dillard	14. NAME OF HUSBAND OR WIFE Frank Burkett
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 495-03-3894	17. INFORMANT Mr Frank Burkett 104 So Delaware Butler Mo
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 24 Hrs
DUE TO (b) Myelogenous leukemia +		
DUE TO (c) Leiomyomatous Tumor Duodenum + Pancreas		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Butler Mo	COUNTY Butler	STATE Mo
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21. I attended the deceased from **November 59** to **16 Jan, 1960** and last saw her alive on **16 Jan, 1960**.
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wallace H. Graham M.D.	22b. ADDRESS 518 Argyle Bldg.	22c. DATE SIGNED 18 Jan '60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan 19 1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR Sheil Colonial Chapel Kansas City Mo	25. DATE RECD. BY LOCAL REG. 1-18-60	26. REGISTRAR'S SIGNATURE Neva Marshall
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BY AFFIDAVIT OF Funeral Home
Wallace H. Graham
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 _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Thomas A. Smith

Licensed Embalmer No. 4954

P. O. Address K.P. Mc

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.

JUN 7 1960