

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005818

FILED VS FEB 23 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 167 B

STATE FILE NUMBER

INDEXED

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|--|--|---|--|---|---|--|--|---|---|--|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY Greene | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield | | Length of stay in 1b | | c. CITY OR TOWN Springfield | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 619 N. Campbell | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First James Middle W. Last Burke | | | | 4. DATE OF DEATH Month February Day 8, Year 1960 | | | | | | | | | |
| 5. SEX Male | | 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 25 Sept. 1870 | | 9. AGE (last birthday) 89 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Employee | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | | 11. BIRTHPLACE (City and state or country) Kentucky | | | 12. CITIZEN OF WHAT COUNTRY USA | | | | |
| 13a. FATHER'S NAME Marion Burke | | | | 13b. MOTHER'S MAIDEN NAME Nancy McCoy | | | | 14. NAME OF HUSBAND OR WIFE Effie Burke | | | | | |
| 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. Unknown | | | 17. INFORMANT Effie Burke (Wife) Springfield, Mo. | | | Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. pyelonephritis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Sen. arteriosclerosis, Acute bronchitis, Chronic | | | | | | | 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 | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. OTHER CAUSE OF INJURY OCCURRED. (Enter status of injury in PART I or PART II of item 18.) Diabetes, Pulm emphysema, Pancreatitis | | | | | | | | | |
| 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 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 12-12-56 , to 2/8/60 and last saw him alive on 2/8/60 Death occurred at 10:30 P on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <i>W. S. Johnson</i> (Degree or title) | | | | | | 22b. ADDRESS 609 Cherry Springfield, Missouri | | | 22c. DATE SIGNED 2-18-60 | | | | |
| 23a. BURIAL, CREATION, REMOVAL (Specify) Burial | | | 23b. DATE 2/11/60 | | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | | | 23d. LOCATION (City, town, or county) (State) Springfield, Missouri | | | | | |
| 24. FUNERAL DIRECTOR Klingner Mortuary ADDRESS Springfield, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 2-18-60 | | 26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i> | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Glen D Williams

Licensed Embalmer No. 465

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.