

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1307

63-042915

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED NOV 18 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in lb 4 months	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. II		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6835 Bellefontaine Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Mr. JOHN EDWARD BOURK			4. DATE OF DEATH Month Day Year November 9, 1963		
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 6-3-1889	9. AGE (last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pine Fitter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Edward Bourk		13b. MOTHER'S MAIDEN NAME Catherine McCarthy		14. NAME OF HUSBAND OR WIFE Bertha Bourk			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Bertha Bourk - of the home	
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
DUE TO (b) Head injury Nov 8					
DUE TO (c)					

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Ch. Brown Syndrome associated w/ cerebral brain damage			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 checked="" 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.) Fell out of bed found on floor by side of bed			
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20c. TIME OF INJURY Hour a.m. p.m. Found on floor by side of bed Nov 8, 1963	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) on ward				
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20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION State Hospital St. Joseph Buchanan Mo	COUNTY	STATE
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21. I attended the deceased from **on Nov. 9 63** to _____ and last saw her/him alive on **11-9-63**
Death occurred at **10:40 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. Frank Thomas MD	22b. ADDRESS St. Joseph Hospital St. Joseph Mo	22c. DATE SIGNED 11-9-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-12-63	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR Hellody-McGilley-Eular Funeral Home	25. DATE RECD. BY LOCAL REG. Nov. 14, 1963	26. REGISTRAR'S SIGNATURE Mrs. Clark Guadell
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Linwood & WOODLAND

(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

12-1-63

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

6-3-1899

Kansas City Board of Election Comm. Office

Record of 12-10-1937

DOCUMENT# 3689

BY AFFIDAVIT OF INFORMANT

F. Thomas, M.D.

MEDICAL CERTIFICATION

ITEM NO.

SHOULD READ

6-3-1889

USE BLACK INK OR TYPEWRITER RIBBON

VS 300
Rev. 4/59

15117

3888

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NOV 26 1963

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Permit Renewed 11-10-63

13-0

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 James W. Wair

Licensed Embalmer No. 4650

P. O. Address K. C., 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.