

FILED AUG 18 1941

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

25957

Do not use this space.

1. PLACE OF DEATH *Randolph*  
 (a) County..... Registration District No. *735*  
 (b) Township..... Primary Registration District No. *3034*  
 (c) City *Moberly* (d) Street No. *McCormick Hospital* Registered No. *16385*  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *CHARLES ANDREW BURKEY*  
 (a) Residence, No. *RFD Clark Mo.* St.  (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Lela Burkey*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Apr. 27-1875*

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>66</i>	<i>2</i>	<i>19</i>		

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Andrain Co. Mo.*

13. NAME *Andrew Burkey*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

15. MAIDEN NAME *Sarah Ann Smith*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Randolph Co. Mo.*

17. INFORMANT (ADDRESS) *Mrs. Lela Burkey*  
*RFD Clark Mo.*

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE *Pleasant Ground* DATE *July-18-1941*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Snow Funeral Home*  
*Moberly Mo*

20. FILED *July 18 1941* *Leah Hillman*  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 16 1941*

22. I HEREBY CERTIFY, That I attended deceased from *July 16 1941* to *July 16 1941*  
 I last saw him alive on *July 16 1941*. Death is said to have occurred on the date stated above, at *11:55 a.m.*

The principal cause of death and related causes of importance were as follows:

*Cerebral Hemorrhage* Date of onset *3:00 p.m.*

Other contributory causes of importance:  
*arterio Sclerosis* *yes*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? *physical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? *no*  
 If so, specify \_\_\_\_\_  
 (Signed) *W. L. McCormick*, M. D.  
 (Address) *Moberly Mo*

720 (Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

No Social Security Number

RECEIVED

District Health Officer No. 10

District File Number 8-41-1515

Date Filed AUG 15 1941

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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*R. M. Carter*

Licensed Embalmer No. 4117

P. O. Address.....

*Moberly 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 this body is not embalmed, above space should be left blank.