MAR 9 1939

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

5320
Do not use this space.

1. PLACE OF DEATH
(a) County Lawson | Registration District No. 399
(b) Township Kan | Primary Registration District No. 1002 | Registered No. 519
(c) City Kansas City (d) Street No. R C Gen Hosp St.
(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 42 yrs. 3 mos. 21 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ruth Burgess
(a) Residence, No. 3712½ E. 12th St.
(Usual place of abode. If no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF Frank Burgess

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-14-1896

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	42	3	21	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. H. W.
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) Mo

FATHER
13. NAME Sherman Robertson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER
15. MAIDEN NAME Mary Catze
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Rena Clark (ADDRESS) R C Gen Hospital

18. BURIAL, CREMATION, OR REMOVAL Pleasant Hill Mo DATE 2-8-39

19. FUNERAL DIRECTOR (NAME) Peter B Faulkner (ADDRESS) 526 Campbell

20. FILED 2/8 19 39 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-5 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-5 1939 to 2-5 1939
I last saw him alive on 2-5 1939 Death is said to have occurred on the date stated above, at 11:45 a m
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cholelithiasis; P.O.	
Cholecystectomy;	1-6-39
120	

Other contributory causes of importance:
Toxic Nephritis
Terminal Bronchopneumonia

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? Yes

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? .....
If so, specify .....

(Signed) O. H. De Manby, M. D.
(Address) R C Gen Hospital

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.

Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

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