

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

Do not use this space  
**20427**  
~~20528~~  
84

1. PLACE OF DEATH  
 County St. Francois Registration District No. 773  
 Township 4 Primary Registration District No. 4464  
 City Farmington No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME John Thomas Burks  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**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 Ellen B. Lang

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 7 1897

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>72</u>	<u>0</u>	<u>14</u>	

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Insurance agent  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) St. Genevieve Mo.  
 (STATE OR COUNTRY)

10. NAME OF FATHER Francis M. Burks

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Genevieve Mo.  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Henry Hunt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Genevieve Mo.  
 (STATE OR COUNTRY)

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 1 1930

17. I HEREBY CERTIFY, That I attended deceased from May 1 1929 to May June 1, 1930 that I last saw him alive on above date, 1930 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Gastric Carcinoma  
46 B (duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) 440 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
 (Signed) J. P. Wattness, M. D.  
6-2, 1930 (Address) Farmington Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Catholic Igton</u>	DATE OF BURIAL <u>6/3 1930</u>
20. UNDERTAKER <u>Needler and Co</u>	ADDRESS <u>Igton Mo</u>

14. INFORMANT Thos. Burks  
 (Address) Farmington Mo

15. FILED 6/3/30 R. J. Johnson  
 REGISTRAR

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.

IMMUNIZATION RECORD

