

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021119

STATE FILE NUMBER

FILED JUL 7 1959 Registration District No. 139 Primary Registration District No. Registrar's No. 29

1. PLACE OF DEATH a. COUNTY Holt		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Maitland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Maitland
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb 60 yrs	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL HENRY BURGESS			4. DATE OF DEATH Month Day Year 6 29 1959		
--	--	--	---	--	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 9 1869	9. AGE (In years at birthday) 89	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
----------------	---------------------------	--	-------------------------------	-------------------------------------	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) reframer	10b. KIND OF BUSINESS OR farming	11. BIRTHPLACE (City and state or country) Ripley Co., Ind.	12. CITIZEN OF WHAT COUNTRY? USA
---	-------------------------------------	--	-------------------------------------

13a. FATHER'S NAME Green Burgess	13b. MOTHER'S MAIDEN NAME Louisa Murray	14. NAME OF HUSBAND OR WIFE Rosetta Napier
-------------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, NO known) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Mrs Rosetta Burgess, Maitland, Mo.
---	------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Institution - Inanition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of the Stomach</u>	<u>9 months</u>
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input 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.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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 <u>4-16-59</u> to <u>6-29-59</u> and last saw him alive on <u>6-27-59</u> Death occurred at <u>6-29-1959 9:15 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) Mabel W Kinney Mrs	22b. ADDRESS Mound City, Missouri	22c. DATE SIGNED 7-1-59
--	--------------------------------------	----------------------------

23a. BURIAL, CREMATION, or other disposal (Specify) Burial	23b. DATE 7/1/1959	23c. NAME OF CEMETERY OR CREMATORY Maitland Cemetery	23d. LOCATION (City, town, or county) (State) Maitland, Mo.
---	-----------------------	---	--

24. FUNERAL DIRECTOR G. M. Stephens	ADDRESS Mayvells	25. DATE RECD. BY LOCAL REG. 7-1-59	26. REGISTRAR'S SIGNATURE James H. Crawford
--	---------------------	--	--

(Licensee's Embosmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

91
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 *S. M. Atchison*

Licensed Embalmer No. *2279*
P. O. Address *Maryville*

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.