

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

66 0032155

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 4 Primary Registration District No. 4012 Registrar's No. 73

FILED AUG 22 1966

VS 300
Rev. 4/59

1 0030
2 0030
3
4 0
5 0
6
7 0
8 2
9 1/3 X
10
11
12 26-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Atchison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rock Port</u>		Length of stay in 1b <u>4 mos.</u>	c. CITY OR TOWN <u>FAIBOAX</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>HERBERT VIEW REST HOME</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	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 <u>A. GLENN BURGESS</u>			4. DATE OF DEATH Month Day Year <u>8-8-1966</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1906</u>
9. AGE (last birthday) <u>59</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER BUS. FILLMORE, MO.</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>SAMUEL BURGESS</u>	13b. MOTHER'S MAIDEN NAME <u>ROSETTA NAPIER</u>
14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>495-26-0744</u>
17. INFORMANT <u>FRED BURGESS, ST. JOSEPH, MO.</u>		Address	
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>Cerebral hemorrhage</u> DUE TO (b) <u>metastatic carcinoma</u> DUE TO (c) <u>carcinoma lung</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>weeks</u> <u>months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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
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 a.m. p.m. Month, Day, Year.	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>1/66</u> <u>3/43p</u> <u>8/8/66</u> and last saw him alive on <u>8/8/66</u> Death occurred at <u>3/43p</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John Wronowicz, M.D.</u>		22b. ADDRESS <u>Rock Port, Mo.</u>	22c. DATE SIGNED <u>8/11/66</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-10-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maitland Cem - Maitland Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>Maitland Mo.</u>
24. FUNERAL DIRECTOR <u>Atchison - Maryville, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-16-1966</u>	26. REGISTRAR'S SIGNATURE <u>Louis Weller-Schlachter</u>

USE BLACK INK OR TYPEWRITER RIBBON

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

B. M. Alchison

Licensed Embalmer No. 2279

P. O. Address Maryville 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.