

FILED FEB 20 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1558

Registration District No. 1

Primary Registration District No. 200

Registrar's No. 44

1. PLACE OF DEATH:
 (a) County Adair
 (b) City or town Rural Liberty Twn.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: XX
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community Life - _____ (Specify whether)
 years, months or days

3. (a) PRINT FULL NAME Mary Belle Burchett
 3. (b) If veteran, name war _____
 3. (c) Social Security No. No

4. Sex Female
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife L. E. Burchett
 6. (c) Age of husband or wife if alive 59 years
 7. Birth date of deceased June 23 1888
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 6 14 hr. min.

9. Birthplace Adair Co. Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business Home

12. Name William Wallace

13. Birthplace Columbianna Co. Ohio
 (City, town, or county) (State or foreign country)

14. Maiden name Caroline Eitel

15. Birthplace Adair Co. Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Roy E Burchett

(b) Address Libbs, Mo

17. (a) Burial (b) Date thereof Feb. 8 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pratt Cem.

18. (a) Signature of funeral director Glenn E. Kent & Son

(b) Address Green City, Mo.

19. (a) Feb. 7/41 (b) Spencer L. Treame
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Adair
 (c) City or town Treewcastle Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day Feb.
 year 1941 hour 3 minute 8 P. M.

21. I hereby certify that I attended the deceased from Dead on my arrival 19____;
 that I last saw h_____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration _____

Due to Tuberculosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. L. Sussman (M.D. or other) _____

Address Kirkville, Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

128
RECEIVED

District Health Officer No. 10

District File Number 2-41-378

Date Filed FEB 19 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.....

Not Embalmed

Registered Apprentice No.....

working under my personal supervision..

Signed

Archie W Wade

Licensed Embalmer No.

3037

P. O. Address

Green City m

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 153-8

Registration District No. 1

Primary Registration District No. 200

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Adair
 (b) City or town Liberty T.P.
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community _____ (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Mary Belle Burchett

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 52 Months 6 Days 14 If less than one day _____ hr _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

DEATH CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Tuberculosis of Lung duration of

Due to several years.

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. B. Sumner, M.D. Boomer (M.D. Registrar)
 Address Nashville, Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-1558