

FILED FEB 5 1945

Registered District No. _____

Primary Registration District No. 4009

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Andrew
 (b) City or town Savannah mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Dr. Nichols Sanatorium
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days (Specify whether
 In this community 3 days 0 years, months or days)

3. (a) PRINT FULL NAME Albert Leroy Burchett
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 499-16-4580

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced 2
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept 23 - 1885
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>59</u>	<u>3</u>	<u>15</u>		hr. _____ min. _____

9. Birthplace Sulavine Co mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
 12. Name un known
 13. Birthplace un known 9
 (City, town, or county) (State or foreign country)
 14. Maiden name un known
 15. Birthplace un known 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Eugene Burchett

(b) Address Browning mo

17. (a) B (b) Date thereof 1-11-45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Browning

18. (a) Signature of funeral director E. C. Burt

(b) Address Savannah mo

19. (a) 1-11-45 (b) F. H. Forlechner
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 5-8
 (c) City or town Browning mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? no 1 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8
 year 1945 hour 11 a.m. minute _____ M.

21. I hereby certify that I attended the deceased from Jan 6
 _____, 1945, to Jan 8, 1945
 that I last saw him alive on Jan 8, 1945
 and that death occurred on the day and hour stated above.

Immediate cause of death Efferent nerve block while administering anesthetic for plastic surgery reconstructing a lower lip.
 Due to _____
 Due to _____

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 0

23. Signature J. E. Manning (M. D. or other) _____

Address Savannah mo Date signed 1/8/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

FEB 8 1945

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..... *E. C. Breit*

Licensed Embalmer No. *2650*

P. O. Address *Evansville, Ind.*

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.

Registration District No. *2*Primary Registration District No. *4009*Registrar's No. *4*

1. PLACE OF DEATH:

(a) County *Andrew*
 (b) City or town *Savannah*
 (If outside city or town limits, write "RURAL" and name of township)
 (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 _____
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT
FULL NAME*Albert L. Buckhart*3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex *M* 5. Color or
race *W* 6. (a) Single, widowed, married,
divorced *(W)*6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased *Sept 23 1913*
(Month) (Day) (Year)8. AGE: Years *54* Months *3* Days _____
If less than one day _____ min.9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *2/24/45* (b) *J.H. Fitchman*
(Date received by 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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year *1945* hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

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 sta-
tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

.1580