

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **19991**

**FILED** JUL 24 1945

Primary Registration District No. **3008**

Registrar's No. **206**

1. PLACE OF DEATH:

(a) County **Callaway**  
(b) City or town **Fulton**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **State Hosp # 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **33 days**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

**Sarah E. Burgess**

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **Female**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Joe Burgess**

6. (c) Age of husband or wife if alive, years **24**

7. Birth date of deceased **aug 24 1874**  
(Month) (Day) (Year)

8. AGE: Years **70** Months **10** Days **6**  
If less than one day hr. min.

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

10. Usual occupation **DR**

11. Industry or business

12. Name **John E. Phelps & Sons**

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

14. Maiden name **Sophronia**

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

16. (a) Informant **Records**

(b) Address

17. (a) **Removal** (b) Date thereof **6/30/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Troy, Mo**

18. (a) Signature of funeral director **Walter Funeral Home**

(b) Address **Fulton, Mo (D.C. Browning mgr)**

19. (a) **6-30-45** (b) **Jesse Moseley**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Lincoln**  
(c) City or town **Sioux**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **14**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **30**  
year **1945** hour **12** minute **20** P.M.

21. I hereby certify that I attended the deceased from **5-29-1945** to **6-30-1945**  
that I last saw him **alive** on **6-30**  
and that death occurred on the date and hour stated above.

Immediate cause of death **bronchitis pneumonia myocarditis**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **930**

Duration

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?

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

23. Signature **T. E. Stennell** (M. D. or other)  
Address **Fulton mo** Date signed **6/30/45**

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

14-1-10

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-13-45

SEP 20 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 Wenzel C. Browning

Licensed Embalmer No. 2724

P. O. Address Fullon md

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.