

**FILED DEC 3 1945**

Registration District No. **256**

Primary Registration District No. **1001**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County **Jasper**  
(b) City or town **Jasper**  
(c) Name of hospital or institution: **St. Johns Hosp**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **7 days**  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Illia** (b) County **Illcoo**  
(c) City or town **near Miami**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **South East of Miami**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Maud Ellen Burgin**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **May 4 1885**  
(Month) (Day) (Year)

8. AGE: Years **60** Months **6** Days **7** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business **Housewife**

12. Name **Maud Paeles**

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

14. Maiden name **Mamie Johnson**

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

16. (a) Informant **A. E. Burgin**

(b) Address **Miami, Okla**

17. (a) **Burial** (b) Date thereof **11/14/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ottawa Okla**

18. (a) Signature of funeral director **V. O. Casper**

(b) Address **Miami, Okla**

19. (a) **11-17-45** (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Month **11** day **11** year **1945** hour **10:30 PM** minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from **Nov-5-45** to **Nov-11-45** that I last saw her alive on **Nov 11 - 1945** and that death occurred on the date and hour stated above.

Immediate cause of death **Diabetic Mellitus**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy **101**

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) (c) Means of injury \_\_\_\_\_

23. Signature **P. B. Dunder** (M. D. or other) \_\_\_\_\_

Address **Seneca Mo** Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1404

45-11-895

**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 *Cecil A. Hamble*  
Licensed Embalmer No. 3590  
P. O. Address *Jagers 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 this body is not embalmed, fact should be so stated above.**

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Jasper

(b) City or town Joplin  
(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

**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 \_\_\_\_\_

**3. (a) PRINT FULL NAME** Maud E. Burger

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 \_\_\_\_\_ years

7. Birth date of deceased May 4 1940  
(Month) (Day) (Year)

**8. AGE:** Years 60 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day)  
hr. \_\_\_\_\_ min.

9. Birthplace Indian Territory  
(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) 12-19-40 (b) (M. E. Jones)  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

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

MOTHER FATHER

37518