

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(c) Name of hospital or institution: South East Hospital
(d) Length of stay: In hospital or institution 6 days
In this community Poplar Bluff

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler
(c) City or town Poplar Bluff
(d) Street No. Rural
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME William Calvin Burgin

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased Oct 20 1868

8. AGE: Years 78 Months _____ Days 26 If less than one day hr. _____ min. _____

9. Birthplace Butler Co. Mo.

10. Usual occupation Farmer

11. Industry or business _____

12. Name Allen Burgin

13. Birthplace Butler Co. Mo.

14. Maiden name Don't know

15. Birthplace _____

16. (a) Informant Mrs. Ellen G. Kessie

(b) Address 1116 Reynolds Medical Dr. Poplar Bluff Mo

17. (a) Burial (b) Date thereof 11-18-46

(c) Place: burial or cremation Woodlawn Cemetery Poplar Bluff Mo

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 11-23-1946 (b) G. C. Summers

MEDICAL CERTIFICATION

10. DATE OF DEATH: Month 11 day 16 year 1946 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from 11-12 to 11-16 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Failure
Rapid auricular fibrillation
Cardiac decompensation
Myocardial infarction?

Other conditions: _____
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? _____
(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 _____
Signature Alfred M. Estes (M. D. or other) _____
Address 225 W. Main Jackson Date signed 11-21-46

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

Health Officer No. 4

File Number 1246-292

Filed 12-2-46

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

W. H. Ester

Licensed Embalmer No.

3568

P. O. Address

Ospe Die 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.