

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 9 1949

State File No. **12032**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **387**

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

39
2

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|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN West Plains | |
| c. LENGTH OF STAY (in this place) 3 yrs | | d. STREET ADDRESS (If rural, give location) 703 E. Main | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 533 E. Elm | | | |

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|---|--|-------------|---|-----------|--|
| 3. NAME OF DECEASED (Type or Print) Joseph N. Burroughs | | | 4. DATE OF DEATH (Month) (Day) (Year) April 29, 1949 | | |
| a. (First) | | b. (Middle) | | c. (Last) | |

| | | | | | | | | | | | | | | | |
|--------------------|--|-------------------------------|--|---|--|------------------------------------|--|---|--|------------------------|--|------------------------|--|----------------------|--|
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | | 8. DATE OF BIRTH Jan 4 1872 | | 9. AGE (in years last birthday) 77 | | IF UNDER 1 YEAR Months | | IF UNDER 24 HRS. Hours | | IF UNDER 1 MIN. Min. | |
|--------------------|--|-------------------------------|--|---|--|------------------------------------|--|---|--|------------------------|--|------------------------|--|----------------------|--|

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|---|--|---|--|--|--|--|--|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney | | 10b. KIND OF BUSINESS OR INDUSTRY Attorney | | 11. BIRTHPLACE (State or foreign country) Howell Country, Mo. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
|---|--|---|--|--|--|--|--|---|--|--|--|

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|--|--|--|---|--|--|--------------------------------------|--|--|
| 13a. FATHER'S NAME Joseph Aaron Burroughs | | | 13b. MOTHER'S MAIDEN NAME Mary Catherine Acree | | | 14. NAME OF HUSBAND OR WIFE X | | |
|--|--|--|---|--|--|--------------------------------------|--|--|

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|--|--|-----------------------------------|--|---|--|--|--|---------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Hoyt Ostasander Okmulgee, Okla. | | | | ADDRESS | |
|--|--|-----------------------------------|--|---|--|--|--|---------|--|

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|--|--|--|--|--|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) probably coronary thrombosis | | | | | | | |
| | | ANTECEDENT CAUSES | | | | | | | |
| | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | | | | |
| | | DUE TO (b) _____ | | | | | | | |
| | | DUE TO (c) _____ | | | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS | | | | | | | |
| | | Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |

not attended by a physician

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|------------------------|--|----------------------------------|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|----------------------------------|--|--|--|---|--|

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|--|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
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|--|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
|--|--|--|--|----------------------------|--|

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **8:20a m.**, from the causes and on the date stated above.

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|--|--|-------------------|--|--|--|--------------------------------|--|
| 23a. SIGNATURE W. J. Handley M.D. local registrar | | (Degree or title) | | 23b. ADDRESS City Hall Springfield Mo | | 23c. DATE SIGNED 5/2-49 | |
|--|--|-------------------|--|--|--|--------------------------------|--|

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|---|--|-------------------------|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 5/2/49 | | 24c. NAME OF CEMETERY OR CREMATORY Oaklawn | | 24d. LOCATION (City, town, or county) (State) West Plain, Mo. | |
|---|--|-------------------------|--|---|--|--|--|

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|--|--|---|--|--|--|---------------------------------|--|
| DATE REC'D BY LOCAL REG. 5-2-49 | | REGISTRAR'S SIGNATURE W. J. Handley M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE H. H. Lohmeyer | | ADDRESS Springfield, Mo. | |
|--|--|---|--|--|--|---------------------------------|--|

(Licensed Embalmer's Statement on Reverse Side)

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Walter E Hamilton.....

Licensed Embalmer No. 3808.....

P. O. Address Springfield, 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.