

FILED AUG 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27598

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 268

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sedalia</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Sedalia</u>	
c. LENGTH OF STAY (In this place) <u>19 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>311 E. Johnson</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>311 E. Johnson</u>		d. STREET ADDRESS (If rural, give location) <u>311 E. Johnson</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Helen</u> b. (Middle) <u> Mae</u> c. (Last) <u>Burns</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 5 1949</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 18, 1914</u>
9. AGE (In years last birthday) <u>35 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) <u>Spring Valley, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George Campbell</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Mr. Walter Burns</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Walter Burns - 311 E. Johnson, St. Sedalia</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebrovascular</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Cloxx on brain</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>394x</u>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) <u>Sedalia Pettis Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 <u>8/3</u> , 19 <u>49</u> , to <u>8/5</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8/5</u> , 19 <u>49</u> , and that death occurred at <u>10:30 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Dr. W. E. Alving, M.D.</u>		23b. ADDRESS <u>104 1/2 W. Main Sedalia, Mo.</u>	23c. DATE SIGNED <u>8/6/49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug 9, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Annex</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>
DATE REC'D BY LOCAL REG. <u>8-6-49</u>	REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>251 J. L. Wexander, Mo.</u>	ADDRESS <u>Sedalia</u>

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

RECEIVED
AUG 15 1949
District Health Officer No. 8,

District File Number _____
Date Filed 8-19-49

1008 3194

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 J. Paul Albrecht

Licensed Embalmer No. 4245

P. O. Address Seluliam

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.