FILED APR 16 1954

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 14613

BIRTH NO. 17239-54 REG. DIST. NO. 3335 PRIMARY REG. DIST. NO. 3074 Registrar's No. 50

**1. PLACE OF DEATH**
a. COUNTY: Scott
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sikeston
c. LENGTH OF STAY (In this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mo. Delta Community Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Scott
c. CITY OR TOWN: Sikeston
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒
e. STREET ADDRESS (If rural, give location): Route 3, Box 31

1003
0

**3. NAME OF DECEASED** (Type or Print)
a. (First): Linda
b. (Middle): Diane
c. (Last): Burgess

**4. DATE OF DEATH** (Month) 4 (Day) 5 (Year) 1954

**5. SEX**: Female 3

**6. COLOR OR RACE**: Negro

**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Never Married

**8. DATE OF BIRTH**: 3-27-1954

**9. AGE** (In years last birthday): —
IF UNDER 1 YEAR: Months —, Days 9
IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired):

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (City and State or Foreign Country): New Madrid Co., Missouri

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13a. FATHER'S NAME**: Illegitimate

**13b. MOTHER'S MAIDEN NAME**: Helen Burgess

**14. NAME OF HUSBAND OR WIFE**: 0

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): 0
(If yes, give war or dates of service): 0

**16. SOCIAL SECURITY NO.**: 0

**17. INFORMANT'S SIGNATURE OR NAME** / ADDRESS: Helen Burgess, Sikeston, Mo. r. 3

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Vitamin — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

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.*

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** YES ☐ NO ☒

**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):

**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.:

**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐

**21f. HOW DID INJURY OCCUR?**:

22. *I hereby certify that I attended the deceased from* 5/4, 1954, *to* 5/5/, 1954, *that I last saw the deceased alive on* 5/4, 1954, *and that death occurred at* 5:30 A.m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): William J. Arnquson, MD

**23b. ADDRESS**: Sikeston, Mo

**23c. DATE SIGNED**: 5/6/54

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**24b. DATE**: 4-5-54

**24c. NAME OF CEMETERY OR CREMATORY**: Matthews Mo

**24d. LOCATION** (City, town, or county) (State): Matthews Mo

DATE REC'D BY LOCAL REG.: 4-9-54

REGISTRAR'S SIGNATURE: Mrs Ella Hunter 420.0

**25. FUNERAL DIRECTOR'S SIGNATURE** / ADDRESS: Grand Father Burgess

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
30.48
1003
0

SCOTT CO. HEALTH DEPT.

CO. FILE No. _____

DATE RECEIVED APR 12 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No. 454-78

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.