THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30353

BIRTH NO. FILED SEP 20 1954 REG. DIST. NO. 132 PRIMARY REG. DIST. NO. 3021 Registrar's No. 141

1. PLACE OF DEATH
a. COUNTY Grundy
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Trenton
c. LENGTH OF STAY (in this place) 4 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Susans Nursing Home
e. STREET ADDRESS (If rural, give location) 0170 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Carroll
c. CITY OR TOWN Hale
d. Is Residence within limits of a city or incorporated town? Yes ☑ No ☐

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Merdith c. (Last) Burnside

4. DATE OF DEATH (Month) (Day) (Year) Aug 30-1954

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Feb 18-1866
9. AGE (In years last birthday) 88 | IF UNDER 1 YEAR Months 6 Days 22 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Hale Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME A Burnside
13b. MOTHER'S MAIDEN NAME Dont Know
14. NAME OF HUSBAND OR WIFE Addie Burnside

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Mrs Tom Paris ADDRESS Hale Mo

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) Cardio Vascular Renal Dis — INTERVAL BETWEEN ONSET AND DEATH 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio Sclerosis — 1 year
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 442 X
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* Apr, 1954, *to* Aug 30, 1954, *that I last saw the deceased alive on* Aug 30, 1954, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE E. A. Duffy M.D. (Degree or title)
23b. ADDRESS Trenton Mo
23c. DATE SIGNED Aug 31-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/3/1954
24c. NAME OF CEMETERY OR CREMATORY Hale
24d. LOCATION (City, town, or county) (State) Hale Missouri

DATE REC'D BY LOCAL REG. 9/3/54
REGISTRAR'S SIGNATURE Irene Fair 115
25. FUNERAL DIRECTOR'S SIGNATURE Clifford W Kustin ADDRESS Tina Mo

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 20

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Clifford W. Justin

Licensed Embalmer No. 32

P. O. Address Tina Ok

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.