

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32078**

FILED NOV 10 1955

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 326

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		c. LENGTH OF STAY (in this place) 5 days	c. CITY OR TOWN Kirksville
d. FULL NAME OF HOSPITAL OR INSTITUTION Grim-Smith Memorial Hospital		. STREET ADDRESS (If rural, give location) 316 S. Cottage Grove	

3. NAME OF DECEASED (Type or Print)	a. (First) Earl	b. (Middle) L.	c. (Last) Burt	4. DATE OF DEATH (Month) (Day) (Year) October 29, 1955
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 2-14-92	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 8 Days 15	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hamcher	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country) Macon County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Robert Burt	13b. MOTHER'S MAIDEN NAME Emma Lyle	14. NAME OF HUSBAND OR WIFE Lydia Maria Burt
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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)	16. SOCIAL SECURITY NO. 490-10-6015	17. INFORMANT'S SIGNATURE OR NAME Robert Burt	ADDRESS Columbia Mo
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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, assthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 10 min 10 days 20 wks 2 wks
	ANTECEDENT CAUSES DUE TO (b) Thrombocytopenic Purpura		
	DUE TO (c) Cardiac decompensation		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. cerebral edema			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 463X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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 Sept 1947, to Oct 29, 1955, that I last saw the deceased alive on Oct 29, 1955, and that death occurred at 12:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Nielson T. Engle M.D.	23b. ADDRESS Columbia, Mo	23c. DATE SIGNED Nov. 1, 1955
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24a. BURIAL, CREMATION, REMOVAL (Specify) B	24b. DATE Oct 31 1955	24c. NAME OF CEMETERY OR CREMATORY Helton	24d. LOCATION (City, town, or county) (State) Macon County Mo
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DATE REC'D BY LOCAL REG. 11-8-55	REGISTRAR'S SIGNATURE Kate Lambert	25 FUNERAL DIRECTOR'S SIGNATURE M. McCallum	ADDRESS South Gifford Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

JUL 25 1957

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.....
Signature of Student Embalmer

Signed *Clyde M. Collier*.....
Licensed Embalmer No. 3226

P. O. Address ... South Gifford

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.