

Health, Welfare and Public Service  
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 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

19929  
 STATE FILE NUMBER

FILED JUL 15 1957

Registration District No. 1 Primary Registration District No. 5002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u> ✓	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Novinger, Mo. - LIBERTY</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>R. F. D. Novinger</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at the home</u> Length of stay in lb _____		d. STREET ADDRESS <u>Southwest of Novinger</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Elizabeth</u> Last <u>Burchett</u>			4. DATE OF DEATH <u>July, 5, 1957</u> Month <u>July</u> Day <u>5</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1867</u>	9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Adair, County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thadius Warsaw Bozarth</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Spivey</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>None</u>	17. INFORMANT <u>Mrs. Perry Truitt, Novinger, Mo.</u> Address _____		

18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Valvular Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____	_____

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION <u>Novinger, Mo.</u> COUNTY _____ STATE _____
21. I attended the deceased from <u>Jan 1950</u> to <u>July 5, 1957</u> and last saw <u>her</u> alive on <u>July 5, 1957</u> . Death occurred at <u>8:45 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>A. J. Garrison M.D.</u>	22b. ADDRESS <u>Novinger, Mo.</u>	22c. DATE SIGNED <u>7-6-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/7/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ringö Point</u>	23d. LOCATION (City, town, or county) (State) <u>Adair, County, Mo. - 7-6-57</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>Kirksville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-8-1957</u>	26. REGISTRAR'S SIGNATURE <u>Dore W. Rattiff</u>

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 Richard R. Ellis, Student Embalmer No. 542  
working under my personal supervision.

Student Richard R. Ellis  
Signature of Student Embalmer

Signed George W. Dawalt

Licensed Embalmer No. 47

P. O. Address Kirkwood

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.