

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

FILED NOV 12 1957

STATE FILE NUMBER  
38948

Registration District No. 360 Primary Registration District No. 6285 Registrar's No. 176

V. S. 300  
Rev. 1-57

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1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Gasper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Queneweg</u> 0490 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in Hospital, give location) <u>State Hosp #3</u>		Length of stay in lb <u>3 mo</u>	d. STREET ADDRESS (If outside, give location) <u>unknown</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>GILBERT A. BURKHOLDER</u>			4. DATE OF DEATH Month Day Year <u>10 29 57</u>			
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/1873</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life. (If retired)) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	11. BIRTHPLACE (City and state or country) <u>Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
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13a. FATHER'S NAME <u>W. T. Burkholder</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Denny</u>	14. NAME OF HUSBAND OR WIFE <u>widowed</u>
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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. <u>unknown</u>	17. INFORMANT <u>Hospital records</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	_____
	DUE TO (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <u>4200</u>		WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) <u>none</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE
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21. I attended the deceased from <u>7/25/57</u> to <u>10/29/57</u> and last saw her/him alive on <u>10/29/57</u> Death occurred at <u>4:50 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>George Esker M.D.</u> (Degree or title)	22b. ADDRESS <u>State Hospital #3</u>	22c. DATE SIGNED <u>10/29/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-1-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sarcoxie Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sarcoxie, Mo.</u>
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24. FUNERAL DIRECTOR <u>Johnston-Arnce-Simpson</u> <u>Webb City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-7-1957</u>	26. REGISTRAR'S SIGNATURE <u>Arma &amp; Ferry</u>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Jack C. Simpson* .....

Licensed Embalmer No. 4647 .....

P. O. Address Webb City, Mo. ....

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.