

Health,
Welfare
Public
Service

FILED JAN 21 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4203

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 1

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Nevada</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cedar</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>El Dorado Spgs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Nevada City Hosp</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>807 S. Jackson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LIZZIE</u> Middle <u>BURTON</u> Last <u>BURTON</u>			DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>Apr 26, 1979</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Cedar Co mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

13a. FATHER'S NAME <u>John T. Garland</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Pike</u>		14. NAME OF HUSBAND OR WIFE <u>Presant.</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>-</u>		17. INFORMANT <u>Grace Debler</u> Address <u>El Dorado Spgs mo</u>	

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>Cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>cerebral arteriosclerosis</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332X</u>			19. 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.)		
20c. TIME OF INJURY Hour <u>9:15</u> Month <u>Jan</u> Day <u>4</u> Year <u>1958</u> a.m. <u>A</u> 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 COUNTY STATE	

21. I attended the deceased from 1-29-57 to 1-4-58 and last saw her alive on 1-4-58
Death occurred at 9:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert R. Mager M.D.</u> (Degree or title)		22b. ADDRESS <u>El Dorado Springs, Mo.</u>		22c. DATE SIGNED <u>1-7-58</u>	
---	--	---	--	-----------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-6-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nevada City</u>		23d. LOCATION (City, town, or county) (State) <u>Nevada Co mo</u>	
--	--	----------------------------	--	--	--	--	--

24. FUNERAL DIRECTOR <u>Mager, El Dorado Spgs mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-13-1958</u>		26. REGISTRAR'S SIGNATURE <u>Anna J. Ferry</u>	
---	--	--	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 22 1958

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 *Alvin S. Allen*

Licensed Embalmer No. *2844*....
P. O. Address *El Morado Sp*.....

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.