

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012810

STATE FILE NUMBER

FILED MAR 24 1958

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 50

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Marshall</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>Witzgibbon Hosp.</u>		Length of stay in 1b <u>9 days</u>	d. STREET ADDRESS (If outside, give location) <u>Montague Hill</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>John Raymond Burgess</u>			4. DATE OF DEATH Month Day Year <u>March 21, 1958</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1901</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Service Station</u>	11. BIRTHPLACE (City and state or country) <u>Bland Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Charles A. Burgess</u>	13b. MOTHER'S MAIDEN NAME <u>Clarissa N. Campbell</u>	14. NAME OF HUSBAND OR WIFE -----
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>495-36-7480</u>	17. INFORMANT <u>Mrs Martin Stone, Marshall Missouri</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>Uremia</u> 540.0		INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hrs</u>
DUE TO (b) <u>Shock from blood loss.</u>		
DUE TO (c) <u>rupture when partial obstruction</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>red back injury &amp; partial leg paralysis - decubite</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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>2</u>
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from Death occurred at <u>7-45 P.M.</u> on <u>March 24</u> , to <u>3-21-58</u> , and last saw him alive on <u>3-21-58</u> . m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Kelce H. Jones M.D.</u>	(Degree or title)	22b. ADDRESS <u>Marshall, Mo</u>	22c. DATE SIGNED <u>3-22-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-23-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Gardens</u>	23d. LOCATION (City, town, or county) (State) <u>Marshall Missouri</u>
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24. FUNERAL DIRECTOR <u>Campbell-Lewis, Marshall Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3-22-58</u>	26. REGISTRAR'S SIGNATURE <u>Leid H. Reed</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

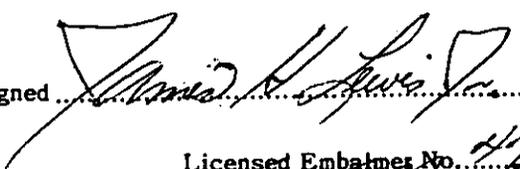
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. 4709.....

P. O. Address Marshall.....

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.