

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035696
STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 484
FILED OCT 21 1958

300
1-57

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau		c. CITY OR TOWN Dexter	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Southeast Mo. Hospital		d. STREET ADDRESS (If outside, give location) 1031 430 No. Poplar	

3. NAME OF DECEASED (Type or print) First Middle Last Percy Pritchett Burns			4. DATE OF DEATH Month Day Year Oct. 3, 1958		
------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1895	9. AGE (In years, IF UNDER 1 YEAR, IF UNDER 24 HRS. birthdays) Months Days Hours Min. 63
-----------------------	----------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------	-------------------------------------------------------------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Auto Parts Co.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Illiopolis, Illinois	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---------------------------------------------------------------------------------------------------------------------------	-----------------------------------	---------------------------------------------------------------------------	-------------------------------------------------

13a. FATHER'S NAME Clay D. Burns	13b. MOTHER'S MAIDEN NAME Minnie Graham	14. NAME OF HUSBAND OR WIFE Europa Burns
--------------------------------------------	---------------------------------------------------	----------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 497-03-1412	17. INFORMANT Mrs. Europa Burns, Dexter, Mo.
---------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------	--------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 13 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral arteriosclerosis	
	DUE TO (c) 331X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus		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 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
-----------------------------------------------------------	---------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------

21. I attended the deceased from death occurred at Sept 20, 1958 to Oct 3, 1958 and last saw him alive on Oct 2, 1958 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Israel M. Hopworth, M.D.	22b. ADDRESS 34 N. Sprigg Cape Girardeau, Mo.	22c. DATE SIGNED 10/11/58
---------------------------------------------------------------------	---------------------------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-5-58	23c. NAME OF CEMETERY OR CREMATORY Dexter	23d. LOCATION (City, town, or county) (State) Dexter, Missouri
------------------------------------------------------------	-----------------------------	-----------------------------------------------------	--------------------------------------------------------------------------

24. FUNERAL DIRECTOR Strickland-Rainey	ADDRESS Dexter, Mo.	25. DATE RECD. BY LOCAL REG. Oct. 17, 1958	26. REGISTRAR'S SIGNATURE Mrs. Homer Cooper
--------------------------------------------------	-------------------------------	------------------------------------------------------	-------------------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 6 1950

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 *Jucille Rainey*

Licensed Embalmer No. *4983*

P. O. Address *Acosta, 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.