

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000231

STATE FILE NUMBER

FILED JAN 12 1959

Registration District No. 38 Primary Registration District No. 5120 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <b>Boone</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Smicrest</b>		Length of stay in 1b _____	d. STREET ADDRESS (If outside, give location) <b>North Subbright St</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>LESLIE Lester Burks</b>			4. DATE OF DEATH Month Day Year <b>January 3 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1907</b>		9. AGE (In years last birthday) <b>51</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commercial pilot</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>aviation</b>		11. BIRTHPLACE (City and state or country) <b>Iberia, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Frank Burks</b>		13b. MOTHER'S MAIDEN NAME <b>Ellen Cooper</b>	
14. NAME OF HUSBAND OR WIFE <b>Virginia Burks</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>486-12-4100</b>	
17. INFORMANT <b>Sign edentification papers on body.</b> <b>Vincent P. Perua M.D. Coroner</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain extensive</b> DUE TO (b) <b>Fractures of skull, comminuted, compound</b> DUE TO (c) <b>Trauma received in air plane accident</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Compound comminuted fractures of left arm + left leg</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Deceased was the pilot of a small aircraft which crashed during a snow storm</b>		20c. TIME OF INJURY Hour Month, Day, Year <b>7:00 p.m. Jan 3 1959</b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Columbia Boone Missouri</b>	
21. I attended the deceased from Death occurred at <b>approx 7:00 P</b> on the date stated above; and to the best of my knowledge, from the causes stated. Last saw her/him alive on _____					
22a. SIGNATURE (Degree or title) <b>Vincent P Perua M.D.</b>			22b. ADDRESS <b>Univ of Mo Med Center</b>		22c. DATE SIGNED <b>3 Jan 1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8 Jan 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boone Creek Cemetery, Mo</b>		23d. LOCATION (City, town, or county) (State) <b>Oscar Missouri</b>
24. FUNERAL DIRECTOR <b>Lynna Sprinkle</b>		ADDRESS <b>Columbia</b>		25. DATE RECD. BY LOCAL REG. <b>Jan 6 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

JAN 13 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was <sup>not</sup> embalmed

~~by me~~ by ....., Student Embalmer No. ....

working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Ernest Sprinkle* .....

Licensed Embalmer No. *4013* .....

P. O. Address *Columbia, 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.