Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-010243
STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 240 Primary Registration District No. 4258 Registrar's No. 8

1. PLACE OF DEATH
a. COUNTY: New Madrid
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Lilbourn — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 7th. St. — Length of stay in Ib
d. STREET ADDRESS (If outside, give location): 7th. St. — Reside on Farm: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: New Madrid
c. CITY OR TOWN: Lilbourn 0720 — Inside Limits: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Will — Middle: — Last: Burch

4. DATE OF DEATH: Month: March — Day: 22 — Year: 1959

5. SEX: Male 2

6. COLOR OR RACE: Colored

7. MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐

8. DATE OF BIRTH: Nov. 21 1887

9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months 4, Days 1 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pensioner Social Security

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Oescola, Arkansas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Bill Burch

13b. MOTHER'S MAIDEN NAME: Katie Beasley

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 495-14-2072

17. INFORMANT: John Burch — Address: 415 Pymaio Ct. Cairo, Ill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c): 331X

INTERVAL BETWEEN ONSET AND DEATH: 2 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 March 6, '59, to March 22, '59 and last saw ~~her~~ him alive on March 22 59
Death occurred at 4 A. M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): G. G. [illegible] M.D.

22b. ADDRESS: Lilbourn Mo

22c. DATE SIGNED: 3/23/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-25-59

23c. NAME OF CEMETERY OR CREMATORY: Sandhill Cem

23d. LOCATION (City, town, or county) (State): New Madrid, Mo.

24. FUNERAL DIRECTOR ADDRESS: Ponder Funeral Home-Lilbourn, Mo

25. DATE RECD. BY LOCAL REG.: 3-24-1959

26. REGISTRAR'S SIGNATURE: H. L. Ponder Deputy.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address Lilbourn, 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.