Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014584
STATE FILE NUMBER

FILED APR 21 1959 Registration District No. 316 Primary Registration District No. — Registrar's No. 137

1. PLACE OF DEATH
a. COUNTY ST. FRANCOIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN RRT 2 FARMINGTON — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) THOMAS DELL NURSHOM 1 WK — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ST. FRANCOIS
c. CITY OR TOWN FLAT RIVER 0942 0 — Inside Limits Yes ☒ No ☒
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First THOMAS Middle W. Last BURNS

4. DATE OF DEATH Month APRIL Day 3 Year 1959

5. SEX MALE 0
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH Feb. 8, 1878
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) MADISON CO, MO.
12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME John Burns
13b. MOTHER'S MAIDEN NAME Harriet COXS
14. NAME OF HUSBAND OR WIFE MARY BURNS.

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.
17. INFORMANT Mrs Joe Robinson Address Esther Mo

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) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinomatosis
DUE TO (c) Probable Carcinoma of the stomach
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 151X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

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 3/30/59, to 3/30/59 and last saw her/him alive on 3/30/59
Death occurred at 7:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W Paul Dennis M.D.
22b. ADDRESS Flat River Mo
22c. DATE SIGNED 4/8/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE April 5, 1959
23c. NAME OF CEMETERY ~~OR CREMATORY~~ HEROD
23d. LOCATION (City, town, or county) (State) CANTWELL, MO.

24. FUNERAL DIRECTOR Raymond Caldwell and Sons ADDRESS Flat River Mo.
25. DATE RECD. BY LOCAL REG. Apr. 13, 1959
26. REGISTRAR'S SIGNATURE Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 R. Caldwell

Licensed Embalmer No. 2531

P. O. Address Flat River

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.