

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020659

FILED JUL 9 1959 Registration District No. 59 Primary Registration District No. 4097 STATE FILE NUMBER Registrar's No. 132

300
1-57

1. PLACE OF DEATH a. COUNTY CASS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY CASS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HARRISONVILLE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN HARRISONVILLE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 604 HARVEY		Length of stay in lb 4 yrs	d. STREET ADDRESS (If outside, give location) 604 HARVEY ST Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WILLIAM Middle BURTON Last BURTON			4. DATE OF DEATH Month JULY Day 1 Year 1959		
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 Dec. 6, 1892	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Pleasant Hill, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William H. BURTON		13b. MOTHER'S MAIDEN NAME ALICE MITCHELL		14. NAME OF HUSBAND OR WIFE NETTIE BURTON
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.	17. INFORMANT Address NETTIE BURTON HARRISONVILLE, 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) Shot wound in forehead			INTERVAL BETWEEN ONSET AND DEATH 0
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 976X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Victim shot himself with 22 rifle		
20c. TIME OF INJURY 9:15 Hour 9:15 a.m. p.m. Month, Day, Year 7/1/59				
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.) Home	20f. CITY, TOWN, OR LOCATION Harrisonville	COUNTY Cass STATE MO
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 9:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE J. B. Taylor (Degree or title) 3		22b. ADDRESS 24. D. Carroll Leavelle Hill Mo.		22c. DATE SIGNED 7/1/59
23a. BURIAL, CREMATION, OR OTHER DISPOSITION BURIAL	23b. DATE 7-3-59	23c. NAME OF CEMETERY OR CREMATORY OAKLAND Cemetery	23d. LOCATION (City, town, or county) (State) HARRISONVILLE, Missouri	

24. FUNERAL DIRECTOR Atkinson - Dickey Harrisonville, Mo.	25. DATE RECD. BY LOCAL REG. July 3-1959	26. REGISTRAR'S SIGNATURE Mrs. Roy Selbee
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

CASS COUNTY
HEALTH DEPARTMENT

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 *Robert W. Atkinson*

Licensed Embalmer No. *4902*
P. O. Address *Hammond, Ind.*

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.