

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027972

FILED VS. SEP 8 1959

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 265

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>			Length of stay in 1b	c. CITY OR TOWN <u>Novinger</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Laughlin Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Walnut Twp</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Earl</u> Last <u>Burress</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3/22/1905</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Adair county Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>William A. Burress</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Anna Hall</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Elizabeth Weber Burress</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT Address <u>Mrs. Mary Elizabeth Burress Novinger, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO (b) <u>AZOTEMIA + LIVER INSUFFICIENCY</u> DUE TO (c) <u>URETERAL OBSTRUCTION + METASTATIC MALIGNANCY OF BLADDER</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>TRANSITIONAL CELL CARCINOMA OF URINARY BLADDER</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>3 weeks</u> <u>UNKNOWN</u>
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 _____ a.m. _____ p.m. _____ Month, Day, Year _____			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>July 21, 1959</u> to <u>AUGUST 25, 1959</u> and last saw him alive on <u>8-25-59</u> Death occurred at <u>11:50 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							22c. DATE SIGNED <u>8-27-59</u>
22a. SIGNATURE (Degree or title) <u>Joseph J. Oklak, D.O.</u>				22b. ADDRESS <u>Kirksville, Mo.</u>		22c. DATE SIGNED <u>8-27-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/29/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Temple Cemetery</u>		23d. LOCATION (City, town, or county) <u>Adair County, Mo.</u>		(State)
24. FUNERAL DIRECTOR <u>Paul ...</u>			ADDRESS <u>Kirksville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-29-1959</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Patch</u>	

(Licensed Embalmer's Statement on Reverse Side)

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JOSEPH J. HELAK, D.D.

MS SEP 8 1980

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold E. Hayes

Licensed Embalmer No. 4890
P. O. Address Kidwell, 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.