

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031497

FILED VS. OCT 5 1959

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STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Gentry				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 6 days		c. CITY OR TOWN King City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 505 E. Empire		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle F. Last Burgess				4. DATE OF DEATH Month Sept. Day 16 Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/25/84	9. AGE (last birthday) 74	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (City and state or country) King City, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A		
13a. FATHER'S NAME John McMillan			13b. MOTHER'S MAIDEN NAME (Unknown)		14. NAME OF HUSBAND OR WIFE John H. Burgess (De)			
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. None		17. INFORMANT J.H. Burgess King City, Mo.			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH 9/11/59		
IMMEDIATE CAUSE (a) Cerebral vascular accident						years		
DUE TO (b) Severe hypertensive cardiovascular disease						years		
DUE TO (c)						years		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Paroxysmal rapid heart action						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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.)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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 9/11/59 to 9/16/59 and last saw her/him alive on 9/16/59 Death occurred at 6:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.				her/him				
22a. SIGNATURE <i>C. A. Potter, M.D.</i> (Degree or title)				22b. ADDRESS Phy. & Surg. Bldg, St. Joseph		22c. DATE SIGNED 9/21/59		
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	23b. DATE Sept. 16, 1959	23c. NAME OF CEMETERY OR CREMATORY King City Cemetery		23d. LOCATION (City, town, or county) (State) King City, Missouri				
24. FUNERAL DIRECTOR Harold E. Keadre		ADDRESS King City, Mo.		25. DATE RECD. BY LOCAL REG. Sept. 29, 1959		26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>		

DOCUMENT

C. A. Potter, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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. Headrel

Licensed Embalmer No. 4609

P. O. Address King City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.