

FILED VS OCT 21 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-036924

STATE FILE NUMBER

Registration District No. 215 Primary Registration District No. 5783 Registrar's No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Miller		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		a. STATE Missouri		COUNTY Miller	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN Ulman		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Ulman		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Glaize twp		Length of stay in lb		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter ^{First} Monroe ^{Middle} Burks ^{Last}				4. DATE OF DEATH Oct. 5, 1959			
5. SEX Male		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 9/11/1872	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Miller Co. Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jessie Burks				14. MOTHER'S MAIDEN NAME Alzena Landsdowne			
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 Gail Burks Iberia, Missouri			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Metastatic Carcinoma to liver DUE TO (c) From Carcinoma of Sigmoid						INTERVAL BETWEEN ONSET AND DEATH 2 Months 6 months 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 1533						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. _____							
20d. INJURY OCCURRED WHILE AT <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 _____, to _____ and last saw her/him alive on _____ Death occurred at 3:40 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) M. E. Humphrey D.O.				22b. ADDRESS Tusculumbia, Mo.		22c. DATE SIGNED 10-7-59.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		10/5/1959		Hickory Point		Iberia, Missouri	
24. FUNERAL DIRECTOR'S ADDRESS Hedges Funeral Homes Inc Iberia, Mo.				25. DATE RECD. BY LOCAL REG. Mo. Oct. 10-1959		26. REGISTRAR'S SIGNATURE Jessie Perkins	

(Licensed Embalmer's Statement on Reverse Side)

The funeral director is responsible for the proper completion of this certificate.

1. Health,
& Welfare
5. Public
Health ServiceS. 300
v. 1-56

0660

The funeral director is responsible for the proper completion of this certificate. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

3961 12 190 SA

10-17

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.....
Walter P. Hayes

Licensed Embalmer No. *4265*

P. O. Address *Benning, 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.