

VIRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 4 6 4 6

FILED VS DEC 18 1959

383

Registration District No. 383 Primary Registration District No. 5655

Registrar's No. 138

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u> Length of stay in 1b <u>39 days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jasper</u> c. CITY OR TOWN <u>Avilla</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R. 2. P.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
---	--	--	--

3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>C.</u> Last <u>Buerge</u>			4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1959</u>		
--	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>10-21-02</u>	9. AGE (last birthday) <u>57</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>Mechanic</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	--	--	--

13a. FATHER'S NAME <u>Amos A. Buerge</u>	13b. MOTHER'S MAIDEN NAME <u>Ivy May Lawson</u>	14. NAME OF HUSBAND OR WIFE <u>Cora Buerge</u>
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>496-01-7034</u>	17. INFORMANT Address <u>San. records, Mo. State San., Mt. Vernon, 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>Bronchopneumonia, left lung</u> DUE TO (b) <u>empyema, right, secondary to bronchopleural fistula</u> DUE TO (c) <u>residual paratracheal malignancy from previous resected/</u> bronchogenic carcinoma, right	INTERVAL BETWEEN ONSET AND DEATH
---	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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 checked="" type="checkbox"/> NO <input 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 <u>8:11</u> 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>Oct. 31, 1959</u> to <u>Dec. 9, 1959</u> and last saw him live on <u>Dec. 9, 1959</u> Death occurred at <u>8:11 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Lewis Galt, M.D.</u>	22b. ADDRESS <u>Mt. Vernon, Mo.</u>	22c. DATE SIGNED <u>12-9-59</u>
--	---	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-9-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jasper Mo</u>
--	------------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <u>Wells Funeral Home Cartersville</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 9-59</u>	26. REGISTRAR'S SIGNATURE <u>Ned Forester</u>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 21 1960

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 William B. Carter

Licensed Embalmer No. 4850

P. O. Address Repalle, 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.