

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 13 1960

=60-029471

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 267

1. PLACE OF DEATH a. COUNTY <u>ADAIR</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKSVILLE</u>		Length of stay in lb <u>10 Wks.</u>		c. CITY OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LAUGHIN HOSPITAL & CLINIC</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>137 N. Hermac</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>BYRON</u> Middle <u>W.</u> Last <u>BURY</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>7</u> Year <u>1960</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>5-3-1912</u>		9. AGE (last birthday) <u>48</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OSTEOPATHIC PYSICIAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OSTEOPATH</u>		11. BIRTHPLACE (City and state or country) <u>PENTON HARBOR, MICH.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>BYRON C. BURY</u>				13b. MOTHER'S MAIDEN NAME <u>WAVA LEON NOWIS</u>				14. NAME OF HUSBAND OR WIFE <u>LUCILLE BURY</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.		17. INFORMANT Address <u>MRS. B. M. BURY, CLAYTON, MISSOURI</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>ACUTE CIRCULATORY FAILURE AND REPERAL THROMBOSIS</u> DUE TO (b) <u>PERICARDITIS + BACTERIAL ENDOCARDITIS</u> DUE TO (c) <u>UNKNOWN - POSSIBLY ABSSESSED TEETH</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>MYCOTIC ANEURYSM OF LEFT ARM</u>								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.)									
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>6-29-60</u> to <u>9-7-60</u> and last saw ^{her} him alive on <u>9-7-60</u> Death occurred at <u>6:35 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree title) <u>Paul Laughlin J. Kb</u>						22b. ADDRESS <u>Kirkville Mo</u>			22c. DATE SIGNED <u>9-8-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>9-9-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lemon</u>			23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>						
24. FUNERAL DIRECTOR ADDRESS <u>DAVIS & DAVIS KIRKSVILLE, MISSOURI</u>				25. DATE RECD. BY LOCAL REG. <u>9-8-60</u>		REGISTRAR'S SIGNATURE <u>Dorise W. Rathff</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 7 1960

EARL LAURENCE, Sr., D.O.

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert B. Davis

Licensed Embalmer No. 4219
P. O. Address Kirkville

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