

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN 24 1967

-60-048667

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6491

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>12 days</b>	c. CITY OR TOWN <b>Chillicothe</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Veteran's Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>515 Madison</b>		
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>K.</b> Last <b>Merle Burton</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>25,</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-26-05</b>	9. AGE (last birthday) <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Chillicothe, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Charles Burton</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Bell</b>		14. NAME OF HUSBAND OR WIFE <b>Flossie Burton</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W.II</b>		16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT Address <b>Flossie Burton, Chillicothe, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung with metastases</b>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
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 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 _____ a.m. _____ p.m. _____	Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR 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 <b>December 13, 1960</b> , to <b>December 25, 1960</b> . Last saw her/him alive on _____. Death occurred at <b>6:40 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>J. M. Zimmerman</i> (Deceased or title) <b>J. M. ZIMMERMAN, M.D.</b>			22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>12-25-60</b> (State)	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-26-60</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <b>Chillicothe, Missouri</b>		
24. FUNERAL DIRECTOR <b>Stine &amp; McClure, Kansas City, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-27-60</b>	26. REGISTRAR'S SIGNATURE <i>H-L. Dwyer</i>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 JAN 27 1961

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Orl Robert*

Licensed Embalmer No. 425

P. O. Address K.C. Mo.

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