

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-039730
STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 137

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 24 1962

1. PLACE OF DEATH a. COUNTY Pike		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pike	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Louisiana		Length of stay in 1b 24 Yrs	c. CITY OR TOWN Louisiana Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pike County Hospital		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1321 So Carolina Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Maggie Lon Burbridge			4. DATE OF DEATH Month Day Year Oct 19 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1891
9. AGE (last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Nursery	11. BIRTHPLACE (City and state or country) Pike County Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME John A. Burbridge	
13b. MOTHER'S MAIDEN NAME Layra B Richard		14. NAME OF HUSBAND OR WIFE Never Married	
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. [REDACTED]	
17. INFORMANT Ray L Burbridge, Clarksville, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO (b) Carcinoma, probably of pancreas DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 wks 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the proximal disease condition given in PART I (a) Fracture of right clavicle, fell in home			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>7/10/62</u> to <u>9/19/62</u> and last saw her/him alive on <u>9/19/62</u> Death occurred at <u>4:25 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Thos H Lemley</i>		22b. ADDRESS M.D. 122 S. 3rd, Louisiana, Mo.	22c. DATE SIGNED 9/19/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/21/1962	23c. NAME OF CEMETERY OR CREMATORY Buffalo Cemetary	23d. LOCATION (City, town, or county) (State) Rte 1 Louisiana Missouri
24. FUNERAL DIRECTOR Sterne Funeral Home, Louisiana, Mo.		25. DATE RECD. BY LOCAL REG. 10-22-62	26. REGISTRAR'S SIGNATURE <i>Bernice Collins</i>

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

ITEM NO. SHOULD READ

VS 300	3
Rev. 4/59	4 1
0822	5 0
8822	6
7 0	7 0
8 2	8 2
9157XF	9 157XF
10	10
11	11
12 7-0	12 7-0
13 2-0	13 2-0

STATE OF MISSISSIPPI

1934

DEPARTMENT OF HEALTH

HEALTH

CERTIFICATE

DEPARTMENT OF HEALTH

XX

STATE OF MISSISSIPPI

1934

21

300

MISSISSIPPI

NO. 1

MISSISSIPPI

IN THE CITY OF JACKSON

DATE

TIME

DEPARTMENT OF HEALTH

HEALTH

CERTIFICATE

DEPARTMENT OF HEALTH

HEALTH

CERTIFICATE

STATE OF MISSISSIPPI

1934

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 J. B. Stene

Licensed Embalmer No. 4039

P. O. Address Louisiana 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.

MISSISSIPPI DEPARTMENT OF HEALTH

STATE OF MISSISSIPPI