

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-010815

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 65 Primary Registration District No. _____ Registrar's No. 14
FILED APR 1 1963

VS 300
Rev. 4/59
1 0210
2 0210
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4 1
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7 0
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9 331X
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12 91-2
13 2.0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Chariton		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Chariton			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Brunswick		Length of stay in 1b 27 years		c. CITY OR TOWN Brunswick Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Geo. Burkhart home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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) May Lilly Decker			4. DATE OF DEATH Month March Day 28 Year 1963		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-8-1907	9. AGE (last birthday) 55	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Osceola, Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Steven Burkhart		13b. MOTHER'S MAIDEN NAME Sarah Johnson	
14. NAME OF HUSBAND OR WIFE Rob Decker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service, no, or unknown) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Address George Burkhart, Brunswick, Mo.			
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronal Hemorrhage (Massive)				INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension				12y x 5	
DUE TO (c) Hypoxemia				12y x 5	
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"/> 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 July 1, 1962 to March 28, 1963 last saw her alive on March 27, 1963 Death occurred at 6:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>J. Burkhart</i> (Degree or title)			22b. ADDRESS Brunswick, Mo		22c. DATE SIGNED 3/29/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-31-1963	23c. NAME OF CEMETERY OR CREMATORY Gilead Cemetery		23d. LOCATION (City, town, or county) Carroll County, Mo.
24. FUNERAL DIRECTOR GIBSON FUNERAL HOME, Carrollton, Mo.			25. DATE RECD. BY LOCAL REG. Mar 29-1963	26. REGISTRAR'S SIGNATURE <i>Howie Smith</i>	

USE BLACK INK OR TYPEWRITER RIBBON

APR 4 1963

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 James F. Gibson

Licensed Embalmer No. 5076

P. O. Address Carrollton, 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.