

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

10775

State File No. \_\_\_\_\_

Registration District No. 334

Primary Registration District No. 5466

Registrar's No. 20

1. PLACE OF DEATH

(a) County Harrison  
(b) City or town Rural Sherman Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community Most of Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Harrison  
(c) City or town Rural Sherman Twp  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Sibyl Watie Burgess

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Ralph Burgess 6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased Feb 26 1883  
(Month) (Day) (Year)

8. AGE: Years 58 Months 0 Days 7 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Harrison Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Joe M. Webb  
13. Birthplace Marion Co Iowa  
(City, town, or county) (State or foreign country)  
14. Maiden name Flannice Pratt  
15. Birthplace Harrison Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph Burgess

(b) Address Bethany Mo

17. (a) Burial (b) Date thereof Mar 5 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Antioch Cemetery

18. (a) Signature of funeral director Joe E. Wheeler

(b) Address Bethany Mo

19. (a) 3/7/41 (b) A. K. ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3  
year 1941 hour 7 minutes 45 A.M.

21. I hereby certify that I attended the deceased from Mar 3, 1941, to Mar 3, 1941,  
that I last saw her alive on Mar 3, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

307 (Specify type of place) \_\_\_\_\_ (e) Means of injury no

23. Signature Ernest L. Wood (M. D. or other) DD  
Address Bethany Mo Date signed 3/5/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

H/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 me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Joe E. Wheeler  
Licensed Embalmer No. 3512  
P. O. Address Bethany 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 this body is not embalmed, fact should be so stated above.**