

27609

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

39
39
X21492

FILED SEP 11 1942
5699

Registration District No. 188

Primary Registration District No. _____

Registrar's No. 8

59
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0

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

1. PLACE OF DEATH:

(a) County. Livingston

(b) City or town. Avalon - Livingston sup
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Home in Avalon.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community. 65 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 59

(c) City or town _____
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? 0 years.

3. (a) PRINT FULL NAME Samuel H. Burgard

MEDICAL CERTIFICATION

3. (b) If veteran, name war. NO.

3. (c) Social Security No. NONE

20. DATE OF DEATH: Month AUGUST day 5th
year 1942 hour 2:30 minute A M.

4. Sex M. 5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

21. I hereby certify that I attended the deceased from 40 to Aug 4, 1942
that I last saw him alive on Aug 4, 1942
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

Birth date of deceased August 26, 1852
(Month) (Day) (Year)

Immediate cause of death _____
Carcinoma of Mouth 7 yrs.
Due to _____
Due to _____

8. AGE: Years 89 Months 11 Days 9
If less than one day _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace dont know, 9
(City, town, or county) (State or foreign country)

Major findings: Of operations 450

10. Usual occupation Retired Farmer,

Of autopsy _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Samuel Burgard,

13. Birthplace dont know 9
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Hollinger,

15. Birthplace dont know, 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Beatrice Wilson,

(b) Address Avalon, Missouri.

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? _____

17. (a) burial, (b) Date thereof 8/6/1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Avalon

While at work? _____ (Specify type of place)

(c) Means of injury _____

18. (a) Signature of funeral director _____

(b) Address Clifford W. Austin, Tina, Mo.

23. Signature Chillicothe Mo (M. D. or health officer)
Address _____ Date signed 8/5/42

19. (a) August 5 (b) Mrs Van Fullerton
(Date received local registrar) (Registrar's signature)

1007

SEP 18 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 _____, Registered Apprentice No. _____ working under my personal supervision.

Signed Clifford W. Austin

Licensed Embalmer No. #3233

P. O. Address Tina, Missouri.

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27609
Registrar's No. 8

Registration District No. 188

Primary Registration District No. 5699

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Rural
(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 _____
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston
(c) City or town Avalon
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Samuel H. Burgard
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day _____
year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I have seen him/her _____ live on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex m 5. Color or race aw 6. (a) Single, widowed, married, divorced w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 26 1884
(Month) (Day) (Year)

8. AGE: Years 89 Months 11 Days 13 If less than one day _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sep 30 '42 (b) Mrs. Nan D. Fullerton
(Date received local registrar) (Registrar's signature)

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

MOTHER FATHER

