S. No. 2
OM—2-43
5-1
1 X35887

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25929

FILED AUG 6 1943

Registration District No. 316 | Primary Registration District No. 3059 | Registrar's No. 104

94
2
1

1. PLACE OF DEATH:
(a) County: St Francois
(b) City or town: Bonne Terre, Mo.
(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 years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED: 94
(a) State: Mo. (b) County: St Francois 152
(c) City or town: Bonne Terre /
(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: James R. Burchett
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: M
5. Color or race: W.
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Cora Maggie Burchett
6. (c) Age of husband or wife if alive: 72 years
7. Birth date of deceased: Aug. (Month) 23 (Day) 1860 (Year)

8. AGE: Years 82 | Months 11 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace: Iowa (City, town, or county) (State or foreign country)
10. Usual occupation: Retired
11. Industry or business .....

FATHER
12. Name: Benjamin Burchett
13. Birthplace: Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Cinda Wright
15. Birthplace: Virginia (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs E W Hyatt
(b) Address: Bonne Terre Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 27-1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Greenscastle Mo
18. (a) Signature of funeral director: Benham Wells
(b) Address: Bonne Terre Mo
19. (a) 7-25-43 (Date received local registrar) (b) Byrdie Buhrmester (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24th year 1943 hour 7 minute 55 P. M.
21. I hereby certify that I attended the deceased from 7-22, 1943, to 7-24, 1943 that I last saw him alive on 7-24, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Intestinal obstruction	5 days
Due to: Carcinoma of sigmoid.	
Due to: 46	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations: Carcinoma of sigmoid — annular constriction
Of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

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: J. Weletin (M. D. or other) MD
Address: Bonne Terre Mo, Date signed 7-25-43

11 19 (Licensed Embalmer's Statement on Reverse Side) 11

RECEIVED

District Health Officer No. 4

District File Number 843-2

Date Filed 8-5-43

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.....

Licensed Embalmer No.....

P. O. Address.....

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.