

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 11 1944

Registration District No. 139

Primary Registration District No. 4221

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Holt
(b) City or town Mound City
(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 16 yrs
In this community 16 yrs
years, months or days (Specify whether)

3. (a) PRINT FULL NAME NEWTON BURROUGHS

3. (b) If veteran, name war World War 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Nov. 14 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 3 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business X

MOTHER FATHER { 12. Name George Burroughs
13. Birthplace Unknown
14. Maiden name Elizabeth Apple
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Wes Charles Kill

(b) Address Keokuk Missouri

17. (a) Burial (b) Date thereof 2 19 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Hope

18. (a) Signature of funeral director James A. Pettigrew

(b) Address Oregon Mo.

19. (a) 2-19-44 (b) Pauline Rawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt

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

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

(e) Citizen of foreign country? X (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17
year 1944 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb 17
1944 to Feb 17 19 44
that I last saw him alive on Feb 17 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 2 hours

Due to _____

Due to 940

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

Major findings: _____
Of operations _____
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 0

23. Signature F. C. Hagan (M. D. or other) _____
Address Mound City Date signed 2-19-44

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

44
1
0

MAR 16 1944

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.....
James H. Pettigrew

Licensed Embalmer No. *3192*

P. O. Address *Oregon 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.