

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7825

FILED MAR 14 1944
Registration District No. 237

Primary Registration District No. 5820

Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Malden - rural Anderson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: residence
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether years, months or days)
In this community 16 years, 2 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Malden - rural
(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 Rev. M. G. BURGE

3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex male 5. Color or face white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ethel Burge
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased May 5 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 7
If less than one day hr. _____ min. _____

9. Birthplace Independence Co. Ark. 1
(City, town, or county) (State or foreign country)

10. Usual occupation farming

11. Industry or business above

MOTHER FATHER

12. Name Marian M. Burge
13. Birthplace Arkansas Mississippi
(City, town, or county) (State or foreign country)
14. Maiden name Mary Jones
15. Birthplace Arkansas Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant EVANS BURGE
(b) Address MALDEN, MO.

17. (a) BURIAL (b) Date thereof 2-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MALDEN, MO.

18. (a) Signature of funeral director Ray Samuel Home
(b) Address Malden Mo.

19. (a) Nov-1-44 (b) Zelda Mason
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 12
year 1944 hour 4 minute _____ a.m.

21. I hereby certify that I attended the deceased from Jan 24 1944 to Feb 12 1944
that I last saw him alive on Feb 12 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Staphylococcus Septicemia

Due to thrust and abscess infection Jan 24/44
Due to _____

Other conditions (Include pregnancy within 3 months of death) 240

Major findings: Of operations _____
Of autopsy _____

Duration _____
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)
(f) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]
Address Malden Date signed [Signature]

RECEIVED

District Health Office No. 2,

District File Number 344-474

Date Filed 3-9-44

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 J. D. Sherman
Licensed Embalmer No. 4086
P. O. Address Malden

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.