

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution McLarnin Hospital
(If not in hospital or institution, give street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community 75 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58

(c) City or town Brookfield 1
(If outside city or town limits, write "RURAL") 2

(d) Street No. 324 6 Brooks
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____ 0

3. (a) PRINT FULL NAME Wm A Burkholder

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12 year 1944 hour 12 minute 15 M.

21. I hereby certify that I attended the deceased from Mar 22, 1944 to Oct 12, 1944, that I last saw him alive on Oct 12, 1944, and that death occurred on the date and hour stated above.

4. Sex M 5. Color of race White

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

6. (b) Name of husband or wife Emily Burkholder

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

7. Birth date of deceased: Oct (Month) 1859 (Day) (Year)

Immediate cause of death Membrane Perforating Duration 2 ds

Due to Arterio Sclerotic Degeneration 2 yrs

Due to Chronic Probable Embolism 3 yrs

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

8. AGE: Years 85 Months _____ Days _____ If less than one day _____ hr _____ min.

9. Birthplace Province of Ont. Canada (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

Major findings: Of operations 13/a

Of autopsy _____

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

MOTHER FATHER

11. Industry or business _____

12. Name Wm Burkholder

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

14. Maiden name Barbara Gotschne

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

16. (a) Informant Lena Dongenitz (b) Address Brookfield

17. (a) Burial (b) Date thereof Oct 15 1944 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rock Hill Cemetery

18. (a) Signature of funeral director Wm J. ... (b) Address Brookfield

19. (a) 10-16-1944 (b) Wm ... (Date received local registrar) (Registrar's signature)

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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury 0

23. Signature Boyd ... (M. D. number) _____ Date signed 10-16-44

Address Brookfield

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

8/2

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 *Norman Burden*

Licensed Embalmer No. 3595

P. O. Address Brookfield 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.