

FRED JUN 29 1945

Registration District No. 43 Primary Registration District No. 100 Registrar's No. 641

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution State Hospital # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs 0 mos 13 ds
(Specify whether years, months or days)

In this community Yes

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Daviess

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

(d) Street No. 1
(If rural, give location)

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

3. (a) PRINT FULL NAME Alma Burton

3. (b) If veteran, name war no

3. (c) Social Security No. nel

4. Sex Female 5. Color or race white

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

6. (b) Name of husband or wife Cleo Burton

6. (c) Age of husband or wife if all years 29

7. Birth date of deceased May 30 1896
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>49</u>	<u>0</u>	<u>10</u>	hr. min.

9. Birthplace Daviess Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business at home

12. Name nyder

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

14. Maiden name Signe Huffman

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

16. (a) Informant Cleo Burton

(b) Address Pattonburg Mo

17. (a) Beard (b) Date thereof 6/10-45
(Month) (Day) (Year)

(c) Place: burial or cremation Pattonburg, Mo.

18. (a) Signature of funeral director Wesman, Son Inc

(b) Address 1946 Calhoun St

19. (a) 6-10-45 (b) Helen J. Fuchs
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6/10 day 10
year 1945 hour 11 minute a M.

21. I hereby certify that I attended the deceased from June 1st 1945 to June 10 1945
that I last saw h...er alive on June 10 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to Had paresis

Due to 3012

Other conditions 3012
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration 34 yrs or more

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 W. E. Collins (M. D. or other) _____

Address State Hospital # 7 Date signed 6/10/1945

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

MOTHER FATHER

1577

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.....

Robert H. Gaylor

Licensed Embalmer No.....

3308

P. O. Address.....

St Joseph, 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.