

FILED AUG 14 1945

State File No. 17

Registration District No. 1118 Primary Registration District No. 5427 Registrar's No. 17

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Rural (Calveras Sup.)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: at Home
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin ³⁶

(c) City or town RURAL (Calveras Sup.) ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. R. 10 ⁰
(If rural, give location)

(e) Citizen of foreign country? No ⁰ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Leona Helm Burt.

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 31 1945 to 7/24 1945
that I last saw the alive on _____ 1945
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife William Burt 6. (c) Age of husband or wife if 3 years 1863

7. Birth date of deceased Sept. (Month) (Day) (Year)

Immediate cause of death: Carcinoma of breast with metastases Duration 4 yrs.

8. AGE: Years 82 Months 10 Days 21 If less than one day hr. _____ min. _____

Due to _____

Due to _____

Other conditions: Hemiplegia
Myocarditis

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

10. Usual occupation Housewife

11. Industry or business own home

12. Name George S Helm

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

14. Maiden name Rebecca Flowers

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

16. (a) Informant Edith Burt

(b) Address 1044 Summit Way

17. (a) BURIAL (b) Date thereof 7/26/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedar Grove Cemetery, Mo.

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) 7/26/45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

PHYSICIAN _____

Underline the cause to which death should be charged statistically. 50

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? _____

(e) Means of injury _____ (Specify type of place)

23. Signature [Signature] (M. D. or other) [Signature]

Address Union Mo Date signed 7-26-45

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 8-13-45

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.....

Joe L. Shibles

Licensed Embalmer No. 3008

P. O. Address.....

Pacific, 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.