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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6427

FILED FEB 19 1946

State File No. \_\_\_\_\_

Registration District No. 194

Primary Registration District No. 5719

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Macon

(b) City or town rural, Berwin

(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Will Burch

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M Color or race W

5. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased May 18 1867

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>6</u>	<u>17</u>	hr. _____ min. _____

9. Birthplace Macon Co Mo

(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name Tom Burch

13. Birthplace SK \_\_\_\_\_

(City, town, or county) (State or foreign country)

14. Maiden name Susan Vandolph

15. Birthplace SK \_\_\_\_\_

(City, town, or county) (State or foreign country)

16. (a) Informant Mr Arthur Burch

(b) Address Macon, Mo

17. (a) Burial (b) Date thereof 12-2-45

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bloomington Cem

18. (a) Signature of funeral director Stephens & Goodding

(b) Address Macon Mo

19. (a) 1-26-46 (b) Smith-Mcneely

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov, day 30

year 1945 hour 25 minute P.M.

21. I hereby certify that I attended the deceased from Oct 1 1944, to Nov 30 1945

that I last saw him alive on Oct 25 1945

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Cardio-vascular disease 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations 93d

Of autopsy \_\_\_\_\_

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 J.P. Conway (M. D. or other)

Date signed 12/4/45

1259 (Licensed Embalmer's Statement on Reverse Side)

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

101023

Dir. No. 2-46-22  
Date Filed FEB 11 1946

**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 *C. L. Stephens*

Licensed Embalmer No. *3057*

P. O. Address *Macon, 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.**

Registration District No. 1198 Primary Registration District No. (5742)

1. PLACE OF DEATH:

(a) County Macon

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

(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 \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Will Burch

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m

5. Color or race w

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

6. (b) Name of husband or wife deceased

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

7. Birth date of deceased may 18  
(Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days \_\_\_\_\_  
(Unless than one day hr. min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) (Burial, cremation, or removal) \_\_\_\_\_

(b) Date thereof \_\_\_\_\_  
(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) (Date received local registrar) \_\_\_\_\_

(b) Arthur McKeely  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

0427