

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12002

FILED MAR 18 1946

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 33

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town North Washington

(c) Name of hospital or institution: State Hospital #32
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 445 yrs 4 mo 17 day
(Specify whether in this community 48 yrs 4 mo 17 day years, months or days)

3. (a) PRINT FULL NAME W. D. BURKHART

3. (b) If veteran, no name war

3. (c) Social Security No.

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife

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

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

8. AGE: Years 84 Months + Days + If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Hospital record

(b) Address Nevada, Mo.

17. (a) Burial (b) Date thereof 3-14-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Nova Funeral Service

(b) Address Nevada, Mo.

19. (a) 3-4-46 (b) Ralynn Jancy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Morgan

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

(d) Street No. 22
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1 year 1946 hour 1 minute 10 P.M.

21. I hereby certify that I attended the deceased from Oct 7 1946 to March 1 1946
that I last saw him live on March 1 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Atherosclerotic heart disease

Due to ✓

Due to ✓

Other conditions: Cholelithiasis +
(Include pregnancy within 3 months of death)
Fever + dysfunction

Major findings: Of operations

Of autopsy: as above stated

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?

23. Signature: R. S. Hall (M. D. or other) W.
Address: Nevada Mo Date signed 3-1-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

Office No. 7,

2-46-187

Date filed

8-8-46

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 Allen E. Hays

Licensed Embalmer No. 1968

P. O. Address Nevada 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.