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FILED JUL 29 1946  
386

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

Registration District No. \_\_\_\_\_

Primary Registration District No. 4082

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Carroll

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

(c) Name of hospital or institution:  
Bogard, Mo.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community ALL her Life. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Bogard Mo.  
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME MARY C. BURTON

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

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

4. Sex FEMALE 5. Color or race White

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

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

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Dec 11 1863  
(Month) (Day) (Year)

8. AGE: Years 72 Months 7 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House Keeper

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

12. Name J. D. Shults

13. Birthplace Don't know. (City, town, or county) (State or foreign country)

14. Maiden name STANDLEY

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

16. (a) Informant William Burton

(b) Address Bogard Mo.

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

(c) Place: burial or cremation Oak Hills

18. (a) Signature of funeral director E. A. Dickerson

(b) Address Bogard Mo.

19. (a) 7-15-46 (b) Emilee Street  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12 year 1946 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 8 to July 12, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolus

Duration 4 days

Due to Blow on head from a fall.

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

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION

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) \_\_\_\_\_ 17

(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 \_\_\_\_\_

23. Signature R. W. Matheny (M.D. or other) 2-10-46

Address Luna, Mo. Date signed 7-15-46

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

21520

Dis. No. .....

District File .....

Date Filed .....

7-27-46

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**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 E. L. Dickerson

Licensed Embalmer No. 2534

P. O. Address Bogard 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. *386*

Primary Registration District No. *4082*

Registrar's No. *87*

1. PLACE OF DEATH:

(a) County *Carroll*  
(b) City or town *Bogard*  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME *Mary C. Buxton*

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex *F* 5. Color or race *w*

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

7. Birth date of deceased: *see*  
(Month) (Day) (Year)

8. AGE: Years *72* Months *7* Days *27* (Less than one day) \_\_\_\_\_  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

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

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (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 *July* 2  
year *1946* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration \_\_\_\_\_

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

Due to \_\_\_\_\_ *1860's*

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *Accident*  
(b) Date of occurrence *July 4 - 1946*  
(c) Where did injury occur? *Bogard Carroll mo*  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
*Home Fall*

While at work? *no* (Specify type of place) (e) Means of injury *no*

23. Signature *R. W. Matthee* (M. D. or other) *De*

Address \_\_\_\_\_ Date signed *8-5-46*

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

**SUPPLEMENTARY**

**ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUIRED**

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

*21826*

