

FILED AUG 21 1946

Registration District No. 37

Primary Registration District No. 2023

Registrar's No. 155

1. PLACE OF DEATH:

(a) County Henry  
(b) City or town Clinton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Wetzel Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 days  
(Specify whether  
In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry  
(c) City or town Putnam  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6 N. N. E of Clinton  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME David Arthur Burch  
3. (b) If veteran, name war -  
3. (c) Social Security No. -

20. DATE OF DEATH: Month Aug day 13  
year 1946 hour 11 minute 00 A.M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive 1 years 1896  
7. Birth date of deceased. 3 (Month) 1 (Day) 1896 (Year)

21. I hereby certify that I attended the deceased from August 5<sup>th</sup>, 1946, to August 13, 1946  
that I last saw him alive on August 13, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Concomitant thrombosis  
Duration \_\_\_\_\_

8. AGE: Years 50 Months 5 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Septic Peritonitis  
Due to Injury to abdominal vessels

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

10. Usual occupation Farmer

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

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

MOTHER FATHER  
12. Name George Burch  
13. Birthplace Henry Co Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name MILLET  
15. Birthplace Ill  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

OPTIONAL  
SUPPLEMENTAL  
INFORMATION  
REQUESTED

16. (a) Informant Rolla Burch

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

(b) Address Clinton Mo  
17. (a) Burial (b) Date thereof 10-13-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) Accident 42  
(b) Date of occurrence Aug 5, 1946

(c) Place: burial or cremation Drakes Chapel cem  
(Specify type of place)

(c) Where did injury occur? Clinton Hwy no. 270  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
7 am

18. (a) Signature of funeral director Fred Wellman  
(b) Address Clinton Mo

While at work? \_\_\_\_\_ (e) Means of Injury \_\_\_\_\_

19. (a) 8-14-46 (b) R. R. Remy  
(Date received local registrar) (Registrar's signature)

23. Signature George Burch (M.D. or other)  
Address Clinton Mo Date signed 8/14/46

1-20

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

00700

DEC 21 1954

REC

DIS

11

DEC 21

7-46-856

8-20-46

SEP 6 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 Fred W. Kewen

Licensed Embalmer No. 2478

P. O. Address Clinton

**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. 137

Primary Registration District No. 3023

Registrar's No. 105-

1. PLACE OF DEATH:

(a) County Henry Clinton  
(b) City or town Henry Clinton  
(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 David A. 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 s

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

7. Birth date of deceased mar 1 1943 (Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days 10 If 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(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 Aug year 1943 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 \_\_\_\_\_

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? yes (Specify type of place) worked by (e) Means of injury hammer

23. Signature Geese Welzel (M. D. or other) Harmon

Address C. Clinton Mo Date signed 8/27/43

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

SUPPLEMENTARY

MOTHER FATHER

25786

200944