

No. 2
12-45
17-39
X47070

State File No.

FILED JAN 24 1947
Registration District No.

Primary Registration District No. 3056

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Randolph

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

(c) Name of hospital or institution:
819 So 4th /
(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) _____ (Specify whether

In this community _____

3. (a) PRINT FULL NAME Myrtle H. Burchard

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 Widow

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Oct ? 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

75	2	?	hr. _____ min. _____
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9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER

12. Name John W. Hale

13. Birthplace No data (City, town, or county) (State or foreign country)

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant Mrs F.M. Boyse

(b) Address Batavia, Iowa

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15-47 (Month) (Day) (Year)

(c) Place: burial or cremation Moberly, Mo

18. (a) Signature of funeral director Mahan and Son

(b) Address Moberly Mo

19. (a) 1-15-47 (Date received local registrar) (b) Leah Sheehan (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) county Randolph

(c) City or town 819 So 4th
(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 Jan day 13
year 1947 hour _____ minute 15 P.M.

21. I hereby certify that I attended the deceased from Nov 25/46 to Jan 13/47
that I last saw her alive on Jan 13/47 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Jan 4/47

Due to arterial hypertension

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) (a) Means injury _____

23. Signature Dr. R.E. Hyde (M. D. or other) _____

Address Moberly Mo Date signed 1/15/47

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

JAN 29 1947
RECEIVED
District Health Officer No. 10
District File Number 47-174
Filed JAN 23 1947

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 Frank D. DeWitt
Licensed Embalmer No. 3021
P. O. Address Moberly 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.