

National Office of Vital Statistics

FILED JUL 19 1948

Registration District No. **10**Primary Registration District No. **5409**Registrar's No. **32**

1. PLACE OF DEATH:

(a) County **Douglas**
 (b) City or town **Ava Rural Miller**
 (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 **O. Clell Burchell**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Lissie Turner Burchell** 6. (c) Age of husband or wife if alive **66** years
 7. Birth date of deceased **December 3, 1886**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 5 21 hr. min.

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

10. Usual occupation **Farming**

11. Industry or business.....

12. Name **Jasper Burchell**

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

14. Maiden name **Sarilda Scott**

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

16. (a) Informant **Lissie Burchell**
 (b) Address **Ava, Mo**

17. (a) **Burial** (b) Date thereof **5-29-48**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Basher**

18. (a) Signature of funeral director **Clinkingbeard Funeral Home**
 (b) Address **Ava, Missouri**

19. (a) **July 9-48** (b) **Walter Bushman**
 (Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Douglas**
 (c) City or town **Missouri Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Route 2**
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **24**
 1948 year hour **8** minute **P.** M.

21. I hereby certify that I attended the deceased from **2-9-**
 19**48** to **2-9-** 19**48**
 that I last saw h.i.m. alive on **2-9-** 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial degeneration**
 Duration

Due to.....

Due to.....

Other conditions **Complete Heart block**
 (Include pregnancy within 9 months of death)

Major findings:
 Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause of 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?..... (Specify type of place)

While at work?..... (e) Means of injury **2**

23. Signature **Dr. P. P. Healy** (M. D. or other) **DD**

Address **Ava, Mo** Date signed **5-28-48**

RECEIVED

District Health Officer No. 6,

District File Number 748-830

Date Filed JUL 16 1945

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 W B Hutchinson

Licensed Embalmer No. 34 31

P. O. Address Ma 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.