

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42475

BIRTH NO. 48-792,49 REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 2

46

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

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>	
c. LENGTH OF STAY (If this place) <u>10 days</u>		d. STREET ADDRESS (If rural, give location) <u>1031 N. 3rd</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Constance</u>	b. (Middle) <u>Sue</u>	c. (Last) <u>Burk</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12-31-48</u>
-------------------------------------	-----------------------------	------------------------	-----------------------	---

5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W. M.</u>	8. DATE OF BIRTH <u>12-20-48</u>	9. AGE (In years last birthday) <u>10</u>	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Mins.
-----------------	---------------------------	---	----------------------------------	---	----------------------	------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>West Plains Mo.</u>	12. CITIZEN OF WHAT COUNTRY?
---	-----------------------------------	--	------------------------------

13a. FATHER'S NAME <u>Wm. Burk</u>	13b. MOTHER'S MAIDEN NAME <u>Esmead Gilliam</u>	14. NAME OF HUSBAND OR WIFE
------------------------------------	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Paul Burk</u>	ADDRESS <u>West Plains Mo.</u>
---	----------------------------------	--	--------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia - Broncho</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity (6 1/2 mo.)</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>771.7 10"</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	---	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from 12/20, 1948, to 12/31, 1948, that I last saw the deceased alive on 12/31, 1948, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title)	23b. ADDRESS <u>West Plains Mo.</u>	23c. DATE SIGNED <u>1-5-49</u>
---	-------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>1-1-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Howell Co. Mo.</u>
---	-------------------------	---	---

DATE REC'D BY LOCAL REG. <u>Jan 29-49</u>	REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>West Plains Mo.</u>
---	--	---	--------------------------------

RECEIVED 2-2-49
District Health Officer No. 5,
District File Number 24985
Data Filed 2-2-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.